CONTENTS

SOCIOLOGY OF HEALTH AND MEDICINE

VALENTINA MARINESCU, **RAMONA MARINACHE**, *Foreword: sociology of health and medicine*

ALEXANDRA CIOCĂNEL, *How to choose among different therapeutic options? Patients' Registers of Valuing in Mediating Homeopathy and Biomedicine*

JEMISENIA JOHN OLUWASEYI, **EZENAGU NNEDINMA ROSELINE**, **ADEJOH AROME**, *Socio-Economic Status and Women's Healthcare Utilization: A Study of Selected Areas in Nigeria*

RAHUL BHAUMIK, *Snakes, Snakebites and British Medical-Zoological Engagement in Early Colonial India: Health, medicine and Ideology*

CARMEN VOINEA, *Plastic surgery phenomenon among South Korean women. The instrumental body in a rite of passage to the normative 'Innocent Glamour'*

INTERNET PRIVACY

CHIKEZIE EMMANUEL UZUEGBUNAM, **HENRY CHIGOZIE DURU**, *Privacy concerns on the Internet: investigating the attitudes and behaviours of young Internet users to online anonymity*

BOOK REVIEW

NICHOLAS A. JOHN, *The age of sharing*, Polity Press, 2017

RITA CHARON, *Narrative Medicine – Honoring the stories of illness*, Oxford University Press, 2006

THE AUTHORS

FOREWORD: SOCIOLOGY OF HEALTH AND MEDICINE

VALENTINA MARINESCU[1], RAMONA MARINACHE[*]

Sociology of Health and Medicine is a fast growing sub domain of sociology. The sociological scholarly interest on this sub domain grow as more and more studies from medical sciences revealed that health or the lack of it is not only the result of biological conditions, but a result of in intertwining of biological and social conditions (Pescosolido *et al.*, 2011) and also as a consequence of the 'crisis' of scientific medicine determined by people disillusionment with its answers in front of medical and social problems (Lupton, 2003). Thus, social life can be the 'independent variable', and health level the 'dependent one', but also health and lack of health can be the main causes of social problems and/or social change.

A variety of recent studies (one could look at journals like *Sociology of Health & Illness*, *Journal of Health and Social Behaviour*, *Social Theory & Health, Social Science & Medicine*) have shown that the outcomes of the sociological study of health and medicine could help national and international authorities in developing better health policies in a world in which according to *The European Health Report for 2015* of WHO (World Health Organization) the five main causes of premature mortality are cardiovascular diseases, cancer, diabetes and chronic respiratory diseases with the major risk factors being social behaviours alcohol consumption, tobacco use and overweight and obesity. Moreover in the European health policy for the 21st century, *Health 2020*, essential concept are considered to be aspects like 'community resilience', 'sense of belonging', 'sense of control', 'participatory governance', 'life-course approach' or 'empowerment', to name only a few (WHO, 2013). Thus, the existing knowledge on sociology of health and medicine accompanied by future endeavours in the field could contribute not only at the development of the science, but could have long term impact by offering the

[1] Professor Habilitated at the Department of Sociology, Faculty of Sociology and Social Work, University of Bucharest, Romania. E-mail: vmarinescu9@yahoo.com
[*] Assistant lecturer, Faculty of Letters, University of Bucharest. E-mail: ramona.marinache@yahoo.com

Rom. Jour. of Sociological Studies, New Series, No. 1, p. 3–6, Bucharest, 2017

Creative Commons License
Attribution–NoDerives CC-BY-ND 4.0

fundaments for good health public policies that will lead to the reduction of premature mortality.

The articles from this special issue in original empirical (qualitative and quantitative) researches, tackle themes like: homeopathic practices and value that patients ascribe to medical care and treatment; the effects of socio-economic status on Nigerian women's health; the history of Western medical-zoological engagement with venomous Indian snakes within the context of making and consolidation of British health policy in colonial India during the late eighteenth to the mid nineteenth centuries; plastic surgery phenomenon among South Korean women and an analysis the effect of online anonymity, as a privacy issue.

Alexandra Ciocănel's article ("How to Choose Among Different Therapeutic Options? Patients' Registers of Valuing in Mediating Homeopathy and Biomedicine") examines how patients that undergo biomedical and homeopathic forms of therapy value medical care and treatment. Based on an analysis of semi-structured interviews, the author devised what she called "registers of valuing" through which respondents talk about good or bad medical care and treatment. Those analytical devices (e.g. "registers of valuing") lead her to the construction of an analytical framework useful in describing how patients choose among or combine different therapeutic options. The analysis showed that in choosing and in talking about their options, patients accomplish so-called "valuing work", continuously evaluating and giving value to medical care and treatment by employing criteria that include efficacy, professional competence, communication and a suspicion of monetary interests. The four "registers of valuing" identified by Ciocănel set homeopathy and biomedicine in a relationship that simultaneously involves contrast, succession, and continuity. Patients employ registers of valuing to justify their choices as reasonable, simultaneously pragmatic and oriented around a half-articulated philosophy of gentle healing.

The second article entitled "Socio-Economic Status and Women's Healthcare Utilization: A Study of Selected Areas in Nigeria" (by Jemisenia John Oluwaseyi, Ezenagu Nnedinma Roseline and Adejoh Arome) focuses on the effects of socio-economic status on Nigerian women's health and using the data collected using two methods (survey and focus group) the authors describe "women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State". The results of the study reveal that women request health care services especially when they experience acute phases of their chronic disease (for example: hypertension or diabetes). Also, that education, occupation and income have great effects on women's decision, quality of treatment, frequency of visits to the hospital, length and duration of hospital stay, time of visits to the hospital, and the type of health facilities visited. To improve the social reality they described, the authors' recommendation is for social policies that will help Nigerian women to have a better socio-economic status and hence a better utilization of healthcare services.

The third article "Snakes, Snakebites and British Medical-Zoological Engagement in Early Colonial India: Health, Medicine and Ideology" (by Rahul Bhaumik) tries to trace the interesting history of Western medical-zoological engagement with venomous Indian snakes within the context of making and consolidation of British health policy in colonial India during the late eighteenth to the mid nineteenth centuries. The author shows that while the British colonisers began to exploit flora and fauna of the newly subjugated land for their material benefit, they confronted wild Indian creatures like venomous snakes and anxiously noticed the huge mortality from snake poisoning in India. This threw a direct challenge to the healthy livelihood of the colonisers because of their insufficient knowledge about such a variety of snakes and their envenoming powers. The article shows how Indian snakes formed a significant part of the British medical-zoological imagination of Oriental wilderness seen as a cruel, chaotic and disease-laden condition posing a threat to the life and health of the Europeans. At the same time, Bhaumik presents how the difficulties faced in snake-ridden India were engaged with the idea that India was essentially different from Europe: environmentally and medically. This paper concludes that Western medical engagement with venomous snakes and the consequential health measures which flourished under the British agency provided the tools to order and control the snake-ridden landscape of India and paved the way for the assertion of an intellectual superiority over the colonised people. In this regard, Western medicine and health policy, not only as practice but also as ideology, served to justify the colonial rule and became a true instrument of the British Indian Empire.

The fourth article, written by Carmen Voinea ("Plastic surgery phenomenon among South Korean women. The instrumental body in a rite of passage to the normative 'Innocent Glamour'") explores the plastic surgery phenomenon among young South Korean women and aims to depict the motivations of women as agentic subjects and social pressures that lead them to undergo facial modification. Based on field observation in Daegu (South Korea) between 2008–2009, on interviews in Bucharest (Romania) in 2011, mass-media and pop culture analysis and secondary statistical analysis, the author argues that facial modification among young South Korean is motivated by an instrumentalisation of the body as a "vehicle fo success" in personal and professional life.

In their article "Privacy Concerns on the Internet: Investigating the Attitudes and Behaviours of Young Internet Users to Online Anonymity", Chikezie Emmanuel Uzuegbunam and Henry Chigozie Duru started from the assumption that privacy on the Internet is a multi-faceted issue that requires attention on the user's part, both to protect information from third-party data collection and to manage personal impressions across a variety of contexts and relationships. Their analysis investigated the effect of online anonymity, as a privacy issue, among young Internet users in Nigeria, placing their analysis within the framework of the deindividuation, uses and gratifications, and technological determinism theories.

The authors used methodological triangulation in their research, namely a survey made on a sample of 400 was selected from the study population and a structured questionnaire. The findings showed that online anonymity is common among a significant proportion of the users; and that they utilise online anonymity mainly for the purposes of protecting their privacy, shielding themselves against fraud and other Internet harms and abuses, and for the purpose of fun. Similarly, it was found that while the youths perceive online anonymity as socially beneficial, they at the same time view it as potentially destructive. Uzuegbunam and Duru also discovered that anonymity has not had significant impact on the Internet use habit of the respondents. According to their conclusion, this means that it is not a motivating factor that draws them to the Internet, and that it has neither not made them feel free to communicate nor lure majority of them towards communications that are ethically and legally undesirable.

In this special number of Romanian Journal of Social Sciences there are also the reviews of two fundamental books: one for the social study of health, illness, disease and medical practices – Rita Charon, "Narrative Medicine – Honouring the stories of illness" (by Ioana Silistraru), the other for communication studies – Nicholas John, "The Age Of Sharing" (by Ana-Maria Teodorescu). The first book "Narrative medicine – Honouring the stories of illness", although it can be seen as 'the bible' of narrative medicine published in 2006, so far, has not been reviewed in Romanian scholarly journals. The second book "The Age of Sharing" (2017) brings into attention another stringent matter of contemporary societies that relates with all levels of social life, also with health and medical aspects, it's that of 'sharing' in the digital era.

The papers compiled for this issue explore various topics related to sociology of health. The perspectives on this domain are diverse and, as guest editors, we hope that the articles published here will give readers a multifaceted perspective of sociology and health as a distinct research field. We would like to take this opportunity to thank the authors for all their patience during the revising process. Also we express our gratitude towards the reviewers who helped with observations and comments in order to improve the manuscripts received for this issue. Finally, we want to express our gratitude to the editors of the Romanian Journal of Sociological Studies for hosting this special issue on sociology and health.

REFERENCES

LUPTON, D. (2003). *Medicine as Culture. Disease and the Body in Western Societies*. London: SAGE Publications.

PESCOSOLIDO, B., MARTIN, J., MCLEOD, J. AND ROGERS, A. (eds.) (2011). *Handbook of the Sociology of Health, Illness and Healing. A Blueprint for the 21st Century.* London: Springer.

WORLD HEALTH ORGANIZATION. (2016). *The European health report 2015. Targets and beyond – reaching new frontiers in evidence*.

WORLD HEALTH ORGANIZATION. (2013).*Health 2020. A European policy framework and strategy for the 21st century.*

HOW TO CHOOSE AMONG DIFFERENT THERAPEUTIC OPTIONS? PATIENTS' REGISTERS OF VALUING IN MEDIATING BETWEEN HOMEOPATHY AND BIOMEDICINE

ALEXANDRA CIOCĂNEL*

ABSTRACT

This article examines how patients who undergo biomedical and homeopathic forms of therapy value medical care and treatment. Based on an analysis of semi-structured interviews, four *registers of valuing* through which respondents talk about good or bad medical care and treatment are identified, constructing an analytical framework useful in describing how patients choose among or combine different therapeutic options. It is argued that in choosing and in talking about their options, patients accomplish *valuing work*, continuously evaluating and giving value to medical care and treatment by employing criteria that include efficacy, professional competence, communication and a suspicion of monetary interests. These four registers of valuing set homeopathy and biomedicine in a relationship that simultaneously involves contrast, succession, and continuity. Patients employ registers of valuing to justify their choices as reasonable, simultaneously pragmatic and oriented around a half-articulated philosophy of gentle healing.

Keywords: *medical pluralism, registers of valuing, valuing work, homeopathy.*

INTRODUCTION

The co-existence of diverse health care options in all contemporary societies has generated various strands of research that try to make sense of and conceptualize plural uses of therapy and different medical practices. A rich body of anthropological literature has documented pluralism in healthcare in non-Western settings beginning with the 1970s, when the notion of "medical pluralism" gained currency due to Charles Leslie's work on various Asian medical systems that questioned the primacy of biomedicine as a fully developed medicine (Hsu 2008;

* Faculty of Sociology and Social Work, University of Bucharest, alexandra.ciocanel@sas.unibuc.ro

Rom. Jour. of Sociological Studies, New Series, No. 1, p. 7–24, Bucharest, 2017

Creative Commons License
Attribution–NoDerives CC-BY-ND 4.0

Johannssen 2006). Much more recently, the concept of "medical pluralism" has been employed in investigating new forms of plurality in Western medical settings due to the growing popularity of complementary and alternative medicine (CAM) of the last decades (Cant and Sharma 1999). From this perspective and adding new meanings to this concept, various sociological and anthropological studies have looked at changes in national regulations regarding CAM that have re-signified the notion of quackery (Wahlberg 2007), at the various forms of pluralism of therapies integrated in practitioners repertoire of services (Frank 2002; Frank and Stollberg 2006), or at how patients/users choose among or combine different therapeutic options (Barry 2006; Broom 2009; Sharma 1993).

In this article, I examine the co-existence of biomedical and homeopathic therapies through the analytical framework of *registers of valuing*. I first present and illustrate four important registers through which patients justify their choice for homeopathic treatment, in present-day Romania. I then examine the temporal relationships between biomedicine and homeopathy and how their succession or co-presence shapes patients' accounts. Patients' valuing work is informed not only by criteria of judgment, but also on a temporal organization of care. At the end of the paper I argue that the concept of registers of valuing proves to be a useful analytical construct for a more nuanced understanding of medical pluralism, taking into account diverse forms of temporal sequence between therapeutic alternatives.

Registers of valuing are based on criteria for judging what is good medical care and treatment which patients use when justifying their choices among the two therapeutic options. In my approach, I adapted Frank Heuts and Anemarie Mol's (2013) discussion of registers of valuing. Drawing on interviews with various tomato "experts", Heuts and Mol identify five registers of valuing through which these experts talk about *knowing* and *making* a good tomato. In their framework, valuing is seen as an activity that presupposes simultaneously *evaluation* (classifying if a thing is good or not) and *valuation* (making a thing valuable). In their various ways of assessing, appreciating, adapting or improving a tomato, these experts use criteria from different registers of valuing (*e.g*. monetary, handling, sensual, etc.) that sometimes add up but may also be prioritised or downplayed in a compromise against each other. Heuts and Mol's approach is intended as a contribution to the burgeoning field of valuation studies. Drawing on John Dewey's insight on value as performed in practice, these studies propose that attention should be given to processes of making something valuable without disentangling economic from social values (Dussauge *et al* 2015).

When choosing and discussing therapeutic options through different registers of valuing, patients do a form of *valuing work*. They continuously evaluate and value some aspects of their treatments. This idea has been rather neglected in studies that look at therapeutic pluralism from patients' perspectives, although due attention is given to the criteria used in making these kinds of choices (Barry 2006; Broom 2009; Fadlon 2004; Lindquist 2002). Alex Broom (2009), for example,

conceptualizes therapeutic pluralism through the notion of *bricolage*, showing how cancer patients mediate between CAM and biomedicine by relying on three types of knowledge: embodied and intuitive, scientific, and social. In this way, the efficacity of a therapy is assessed through a combination of what patients feel with their own bodies, how patients interpret scientific statistical knowledge regarding medical aspects, and what they hear as rumour about various kinds of treatments and about how others are progressing in their treatment. Although this is an insightful approach for understanding the active search for and combination of therapies on pragmatic grounds, Broom's study is limited to a special category of patients and focuses on knowledge about treatments, treating CAM modalities as a whole without specifying which ones. This misses the fact that choices may be made on embodied, cognitive *and* relational grounds, the role of practitioners being rather neglected from his account, and that they may imply a differentiation between good and bad options that can vary from one situation to another. In this way, other than "combination", it is unclear in his study what kind of relationships are established between CAM modalities and biomedicine in patients' therapeutic trajectories.

Thomas Csordas (2006) argues that different therapeutic options may exist in practice in a relationship of (1) *contradiction*, when they are incompatible and in conflict or competition; (2) *complementarity*, when they have an additive effect or are used for solving different aspects of some medical problem; (3) *coordination,* when they are coordinated for solving different kinds of problems; (4) *co-existence*, when they directly interact in solving different needs. Although Csordas draws attention to the fact that therapeutic options may be strategically employed by patients in their healing *trajectories*, he does not elaborate on the effects of the temporal order in which this trajectory take place. As a distinction based mainly on how patients choose to address a medical problem, this leaves aside the fact the succession of therapeutic options may change how patients understand and value them. Commitment to one type of therapy may also imply developing a lay philosophy of health and illness and of the proper medical care and treatment to address them.

Many scholars draw attention to the pitfalls associated with using the collective term "complementary and alternative medicine" (Cant and Sharma 1999; Frank 2002; Gale 2014). One strand of argument is related to the homogenising effect of this label, since various forms of therapy are brought together under the same umbrella. As Sarah Cant and Ursula Sharma (1999) argue, CAM modalities share only the fact that they have different knowledge bases and state legitimation in comparison to biomedicine; otherwise, they have highly diverse modes of healing and histories. From patients' perspectives, the problem of compartmentalization is ignored when treating CAM modalities as a whole, since there may be a belief that certain kinds of practices may better explain and cure an illness (Harrell 1991, 45). This is why studies are needed that look at the specifics

of CAM modalities and the relationships patients establish between them or with biomedicine. Scholars in the sociology of CAM that study homeopathy have looked mainly at how biomedicine and homeopathy are integrated in medical practice (Borlescu 2011; Cant and Sharma 1995; Frank 2002; Frank and Ecks 2004; Frank and Stollberg 2006). There are only a few studies of homeopathy from patients' perspectives, and these are rather preoccupied with creating typologies of patients/consumers (Barry 2006; Sharma 1992; Whiteford 1999), neglecting the continuous work of evaluating and valorizing that patients do when navigating between different therapeutic options.

MEDICAL PLURALISM AND HOMEOPATHY

Homeopathy is a form of medicine not easy to categorize in a dichotomized framework like modern vs. traditional or Western vs. Eastern, since it has historically been an offspring of Western medicine that has been shaped by various influences and medical theories. Christine A. Barry (2006) argues that, at least for the UK medical setting, the provision of homeopathy is inherently pluralistic. Therapists may be medical or lay; a more biomedical version of homeopathy co-exists with a more spiritual and holistic one; homeopathy may be practiced within the National Health Service or outside, in various community based projects and private practice. In Romania, *Law no.118/2017 regarding the organization and function of complementary/alternative medical activities and practices* and the *Drug Law* recognises the practice of homeopathy, respectively homeopathic remedies as legitimate forms of medical care and treatment. In contrast with other European countries (e.g. UK, France, Germany), in Romania only qualified biomedical doctors can become homeopaths, and homeopathy is practiced only as a private medical practice. Nevertheless, an internal division may be also observed in the Romanian context between *clinical homeopathy* and *classical homeopathy.* The former is closer to biomedical principles and techniques (and intensively promoted by Boiron company, the largest manufacturer of homeopathic remedies), while the latter presents itself as being closer to the principles of a holistic and individualising form of medicine taught by the founder of homeopathy, the German physician Samuel Hahnemann, at the end of the 18th century.

Both versions of homeopathy share two main principles: the law of similars and the law of infinitesimals (Campbell 2013). The law of similars states that "like cures like", or that a sick condition can be cured with the same remedy that when administered undiluted to healthy persons would cause the same symptomatology of the sick condition. Homeopathic remedies are thus produced after *provings*, empirical tests made on healthy people with the undiluted substances, that reveal a symptoms-picture of an original substance. The "law of infinitesimals" or the principle of successive dilutions (in water, water/alcohol, or milk sugar) and

vigorous shakings ("succussions" in homeopathic terms) states that in this way the original substance becomes more potent, even though in the final homeopathic remedy there is no molecule of the original substance. Various theories have been proposed by homeopaths to explain how remedies may work given this condition, but none has been accepted as valid by the biomedical establishment. Explanations have been given in terms of the memory of water hypothesis, quantum theories and information theory (Milgrom 2006; Oberbaum *et al* 2005; Walach 2003).

Both homeopathic approaches share the technique of interviewing patients in order to assess their condition and to prescribe a remedy. In contrast with a synthetic drug, a homeopathic remedy may address simultaneously different types of symptoms, psychological and organic[1], and its prescription requires a very detailed description of a patient's symptomatology. The main difference between the two versions is that classical homeopaths will try to find *one*[2]remedy that matches the patient's constitution and symptomatology through an extensive interview, while clinical homeopaths may prescribe more than one remedy, each addressing one symptom, more similar to the biomedical way of prescribing. This internal division of homeopathy in Romania, although not generated by the differences between biomedically trained and lay homeopaths like in the UK, points to a general tendency in homeopathy in various national settings: some practitioners try to align their practice to biomedical standards, while others try to construct and legitimise homeopathy as a radically different form of medicine (Degele 2005; Frank 2002).

In this paper, I do not attend to the question of how homeopathy is integrated in the national health care system or at the micro-level of medical practice. I aim to answer the question of how patients evaluate and value medical care and treatment, by identifying what criteria they use and how they establish different relationships between biomedicine and homeopathy. Faced with at least two therapeutic options, patients confront the question "What kind of medical care and treatment are worthy of pursuit?". In the *Results* section, I argue that patients answer this question by taking into account and combining at least four different registers of valuing: efficacy, professional competence, communication, and a suspicion of monetary interest.

METHODS

In order to answer this question, I interviewed 17 patients from April to September 2016 in Bucharest, the capital-city and one of the most developed cities

[1] See, for example, the description of the remedy Pulsatilla from a popular homeopathic Romanian site http://www.homeopatie.ro/pulsatilla-121.htm (accessed 27 February 2017)

[2] A procedure not always respected in practice since finding the right remedy is a tentative and difficult process. As such, classical homeopaths may prescribe also a second remedy to solve the acute phases of some condition.

in Romania, and Piatra Neamţ, a small city situated in the economically depressed northeastern region. The interviewees represent a sample built through a snowball-sampling technique: every interviewee was asked at the end of each interview to make a referral to other persons that use homeopathic remedies and go to a homeopathic doctor. As a qualitative study of how patients value their medical care and treatment, this study does not aim at a statistical generalization, but rather at an analytical one in terms of *case-to-case translation* (Firestone 1993). In this way, I do not intend a generalization for some defined population, but I use the conceptual framework proposed by Heuts and Mol (Heuts and Mol 2013) and translate it from a setting oriented around valuing an object like a tomato to a setting in which medical care and treatment become the main focus of peoples' activities of valuing. Consequently, I look at how valuing takes places discursively in interviews and I bracket sociological categories like gender, age, and social status as explanatory variables.

Given that respondents represent a small sample, it is likely that other registers can be found by interviewing additional people, opening up an agenda for future work. My current research does not represent a comprehensive repertoire of valuing registers at national level, but a first attempt at identifying several such repertoires and their discursive use, arguing for the productivity of this concept in understanding patients' justifications for their treatment choices.

All interviewees were intensive homeopathy users and attended homeopathic consultations on a regularly basis. Five of them consulted a classical homeopath, while the rest went to a clinical homeopath, but only two of them (who were also biomedical doctors) knew that there are various forms of homeopathic practice. Since I was interested in gaining an in-depth insight into how persons negotiate multiple therapeutic options, I did not take into account occasional users and people who only rely on self-administrated treatments. This is why I choose the term "patients" instead of "consumers" or "users", since respondents have a sustained relationship with their homeopath. Homeopathy and biomedicine are the main therapeutic options for them, and both are used for treating acute and chronic conditions. Consistent with previous studies of CAM that reported a higher percentage of female rather than the male users, all the interviewees were women, 14 of them were also mothers who currently provided care for their children. Ages ranged between 20 and 70 years and there was great variability in the interviewees' occupational status (dentist, manicurist, engineer, sociologist, student, unemployed, pensioner, etc.).

In the interviews, I followed a semi-structured format, exploring respondents' health experiences with a focus on homeopathic consultations and treatments. The interviews lasted between 35 minutes and two hours, with an average of one hour and seven minutes. There was only one interview of 35 minutes that took place at the respondent's workplace, a context that was not very supportive for the interview. However, this is an interview that I included in

analysis since I managed to discuss all of the main themes and the respondent formulated some important insights about her and her children health experiences. The other interviews took place either in public locations or at the interviewee's home. All the respondents gave their verbal informed consent before taking part in the study, also acknowledging their permission to digitally record the interviews. Interviews have been subsequently fully transcribed. The Ethics Committee of the Faculty of Sociology and Social Work, University of Bucharest, has approved of the research design, validating all measures for protecting the anonymity of the participants and the archival and publication of resulting data. The anonymity of participants has been protected during analysis through assigning a pseudonym.

To analyse the data I used a form of discourse analysis that looks at how cultural and social meanings are used as resources in narrating personal experiences (Johnstone 2008). The interviews may be seen as one more step in the process of judging something as valuable since they are moments in which "the respondent works up and tests the status of her experience, knowledge, and definitions of events against the knowledge, etc., imputed to the interviewer as representative of the culture at large" (Smith 1978, 27). In analysing the transcripts I treated patients' answers as *accounts* since they entail evaluative judgements and reveal what counts for the person using them (Stark 2009, 25).

I coded transcripts by using the ATLAS.ti qualitative data analysis software, taking each account of a health experience and assigning a code for the criterion used when differentiating between good and bad medical care and treatments. In the first round of interview coding I generated a list of 12 common codes, such as: "no-side effects", "disguised interests", "attention", "understandable explanations", etc. I then grouped them thematically as four distinct registers of valuing, specifically: *efficacy*, *professional competence*, *communication*, and *monetary interests*.

RESULTS

Therapeutic efficacy

The first and most important register of valuing medical care and treatment is centred on various constructions of efficacy, of achieving the intended therapeutic results.

In biomedicine, efficacy has been redefined during the last half of century through the terms and procedures of the double-blind randomised control trial (RCT). A clinical trial defines "good care" as an intervention that leads to an improvement of some measurable parameters of health which are greater than the improvement of patients that received a placebo (Mol *et al* 2010). This evaluation technique formulates care and treatment in quantifiable medical parameters and uses statistical knowledge to assess whether a drug is effective or not. In this logic,

homeopathic remedies are ineffective; various systematic reviews of placebo-controlled clinical trials of homeopathic remedies dismiss homeopathy as equivalent to placebo (Ernst 2002; Jonas *et al* 2003). Health-related media reports on homeopathy rely on the scientific credibility of this research and portray homeopathy with scepticism, talking of homeopathic remedies in terms of a “fake”, a “sham” or a “sugar pill”. When reading such an article, one of the respondents reacted:

> I read an article on some website in which the author, a worthless writer, was saying that Oscilococcinum has a concentration of one in a million, that it is like taking nothing, that homeopathy is a sham. But why do you talk without knowing anything about the topic? Did you talk to people that were cured? Did you talk to any physician? Do you have any credentials I don’t know of? I wrote in the comments section […] My family and I and have been taking remedies for ten years and we feel great, and you start commenting on a subject that you don’t know anything about. (Ina, mother of two children, has used homeopathy herself and for her family for 10 years)

This patient questions the authority of the author of the article that dismissed homeopathy, and invokes her own, “lived truth”. This is a common tendency for respondents, to reject or doubt scientific knowledge based on their own experiential knowledge, suggesting a conflict between different methods of assessing therapeutic effect: the pragmatic, “remedies work for me” account versus the scientific, “remedies are similar to placebo” account. In this way, the efficacy of medical care or treatment is evaluated and valued differently by patients and by scientific researchers.

One way of choosing between different therapeutic options is by contrasting homeopathic treatments that are efficacious with biomedical treatments that are not, constructing the efficacy of a treatment as a restauration of a desirable state. Many respondents give an account of their first encounter with homeopathy as an alternative sought after they tried different biomedical treatments that failed to cure a damaging condition. For example, Ioana first heard of homeopathy from an acquaintance who recommended that she go to a homeopath to see if he could find a solution for her five-year old daughter, who was diagnosed with asthma. In the interview, she complained that her daughter had to be taken very often to the hospital. Doctors administered antibiotics to her and treatments based on cortisone that offered only a very temporary solution. After her daughter had many asthma crises, during one critical episode, she decided to take her to a homeopath who prescribed a scheme of treatment with three homeopathic remedies. She took her daughter home where she began to administer them every twenty minutes and managed to get her daughter out of the crisis. During the administration, she telephoned the homeopath several times to inform her about her daughter’s condition. After this experience, she stopped giving her daughter biomedical treatments for asthma, and treated her only with homeopathic remedies whenever

she was in crisis. This kind of account puts biomedicine and homeopathy in a temporal relationship of succession and comparative efficacy, each addressing the same medical problem. In them, respondents actively seek a solution for their problem, testing and in this way evaluating experientially several kinds of treatments.

This temporal succession is sometimes mediated by hearing stories about a spectacular homeopathic healing from relatives or acquaintances. When beginning to use homeopathy, patients may be reinforced in their decision through stories told by their homeopath about successful cases. Thus, a shared sense of valuing is established, in which homeopathic remedies prove to be a good medical treatment, which could solve even the most problematic cases. In interviews, many respondents moved from recounting their own experiences to stories of third-persons. This argumentative work indicates a continuous effort from their part to add evidence to the correctness of their evaluation. These stories act as reassurance in the face of often encountered critiques of homeopathy, or in moments of self-doubt. Because this kind of account is more concrete and related to their everyday concerns than the abstractness of scientific knowledge that denies homeopathies efficacy, respondents may find it more convincing:

> Q: How did you find this homeopath?
>
> Through a recommendation from a friend, who has kids and went with them in very serious conditions that were solved spectacularly. And I said, when I went to the homeopath, that I don't expect it to be miraculous – but this is how it really works. When the remedy is found, practically in half a day, in twelve hours, symptoms diminish by 75 per cent. (Elena, mother of two children, has used homeopathy herself and for her family for five years)

Another way of choosing between different therapeutic options is through a construction of efficacity in terms of treatment with no side-effects, related usually with reference to a "natural" or "gentle" way of healing. This general principle of evaluation of a treatment is often invoked by respondents when they talk about homeopathic remedies as an alternative to drugs based on antibiotics, cortisone or other forms of long-term treatment. These kinds of accounts invoke moments of crucial test, when people follow one of the possible paths that a controversy may take. In a situation of contestation, when a disagreement over the worth of objects is disputed, some will find the objects defective and will diminish their worth based on the same general principle that is apposite for the situation (Boltanski and Thevenot 2006). Synthetic drugs become 'defective objects' for the patients who use homeopathy, since they are associated with negative side-effects, especially with what they see as a general widespread "toxicity", signifying a failure in achieving good medical treatment:

> I took Nitrofurantoin for my kidneys. I took so much, for kidneys, for infections, for this and that, that, how should I say it […] I felt nausea, a

> feeling of nausea, only when I knew I had to take it. And then, I took them in parallel for a while, and after, when I saw that homeopathy works, I didn't take Nitrofurantoin anymore. (Monica, mother of two children, has used homeopathy herself and for her family for 20 years)

When I asked respondents how they imagine that homeopathic remedies work, respondents' answers can be summarized through the following representation: remedies go to the area of the body where something is wrong, and they fix the problem without causing damage. This reiterates the criterion of "no side effects" in valuing medical treatments. Very few of the respondents have tried to elaborate on this circuit, by appealing to some of the elements specific to homeopathic ontology, for example clarifying that humans also have an "energetic body" in which homeopathic remedies act through a transfer of "information".

Even the otherness of homeopathic remedies in relation to the biomedical treatments was presented as a criterion that confers upon them value, because (1) it does not interfere with the other facets of efficacy, and (2) it is a personalised form of treatment:

> I have heard of some remedies; if you hold some kind of stone, it purifies your house … And I put them (homeopathic remedies) in this category, they have this sort of energy, people believe that these things have supernatural powers, which may be so, or may not be so; and this gives them a strange aura, at least to me; but it is a weirdness that I find benign. It is clear to me that they can do no harm, I do not believe too much in them, I cannot say that wow, that this is the reason I feel better lately. (Andreea, has used homeopathy for one year)
>
> I think that this is homeopathy's charm; it is attractive because you can take this remedy for some ailment and I will take it for something else. If you take it for something mental, I will take it for something physical. You take it for left, I for right. (Monica, mother of two children, has used homeopathy herself and for her family for 20 years)

When employing efficacy as a criterion for valuing, respondents refer to a register in which biomedicine and homeopathy are put in temporal relationship of *succession*: a biomedical treatment that failed to cure their disease has been followed by an attempt to find a solution in homeopathy.

When understanding efficacy as a *return to a desirable health state*, respondents reveal a sort of *pragmatism* in their crisscrossing routes between a biomedical doctor and a homeopathic one. Respondents make a continuous work of valuing treatment options, both homeopathic and biomedical, looking for a solution to solve their problem. In contradistinction, when understanding efficacy as a *no-side-effects treatment*, respondents contrast biomedicine and homeopathy, rather than combining them. A homeopathic remedy may be tried in this case as the

first solution, since it is the one from which patients expect no side effects, in comparison with the synthetic drug.

Professional competence

Another criterion for judging good medical care and treatment is professional competence. Respondents aim to be treated by a competent doctor that has the knowledge and skills to cure their ailments, independently of his or her specialty. A good doctor is usually discovered through recommendations from acquaintances or from an Internet source, but the face-to-face encounter is decisive in establishing her competency. In interviews, respondents give various accounts of "bad doctors", who have not manged to properly diagnose a disease, to find the right treatment, to behave as expected during the consultation, or doctors who prescribe treatments that are considered doubtful by patients. They may be homeopaths or biomedical doctors, invoked in interviews through accounts of failed encounters in which a technical aspect of doctors' performance has been negatively evaluated by respondents:

> And I have been, I believe, to ten dermatologists, paediatricians, all of them, and all said that they do not know the cause for dermatitis and there is no treatment for it. One treatment works for some, for some it doesn't. And it is frustrating to be told that we do not know the cause of your condition and so you should try this, and this, and this. (Ana, mother of one child, has used homeopathy for one year mainly for her child)

When patients have a trustworthy relationship with their homeopath, accounts of the doctors' professional competence present another aspect of the temporal order of succession between biomedicine and homeopathy. Patients first go to various kinds of conventional doctors (mostly to their general practitioner) where they are diagnosed and recommended a treatment. Then, a homeopathic consultation follows, where the biomedical diagnosis or medical analyses are taken into account, but the recommended treatment is totally or partially discarded. In this way, *biomedical and homeopathic professional competences are contrasted yet set in a relation of continuity*, rather than a complete disjuncture. This implies a coordination between homeopathy and biomedicine that blurs the therapeutic boundaries between the two options.

Since homeopaths in Romania are medical homeopaths and there are no specialisations in homeopathy, patients perceive the homeopath as a kind of omnipotent doctor, in contrast with biomedicine where, for the same condition, a patient may visit several specialists to receive diagnosis and treatment. This *omnipotence* is also consolidated by attempts to heal diseases that in biomedicine have rather an uncertain status:

> I have many problems and I was looking for a doctor who could treat them all. This is what I found in her (the homeopath). (Maria, has used homeopathy for one year)
>
> The problem is with that negative analysis, he cannot understand why things are the way they are, because from the endoscopy it is clear that I do not have celiac disease (…) and he said that he does not know the cause of my condition and that probably the solution lies in homeopathy, because classical medicine does not have a cure (…) he told me that if I want something that can help me, I should go to his homeopathic clinic because what I have is clearly based on my type of personality.(Andreea, has used homeopathy for one year)

Attending two therapeutic options gives patients the ability to compare and contrast doctors' medical professional competence. Patients usually rely on other registers of valuing as well, in order to compare the two. Interviews reveal that good medical care can be offered by a doctor that not only reveals his technical professional competence, reflected in a proper diagnosis and treatment prescription, but also, as I discuss in the next two sections, by a doctor that knows how to communicate with patients, and who cannot be suspected of having disguised monetary interests.

Medical communication

Good communication between doctors and patients is another criterion for evaluating medical care. In the case of patients that go frequently to a homeopath, their encounter with homeopathy and its specific methodology of consultation shapes their expectancies regarding good medical communication. Numerous studies in medical sociology draw attention to the communication between doctors and patients and the various problems that arise since it takes places as an encounter between people with different agendas (Cicourel 1981; Frankel 1995; Heritage and Maynard 2006). In biomedical encounters, patients' concerns and personal troubles are usually left aside, in a search for technical solutions. As a consequence, various forms of miscommunication arise. This critique of conventional doctors is also often voiced by respondents:

> It seems to me that in homeopathy you are treated differently. I am being spoken with my own terms, as I am a human being that has no studies in medicine. And this matters a lot. When a (conventional) doctor starts to speak in his terms, he can tell you anything, you can ask once, twice, but the third time … he has also other patients, he kicks you out. (Mara, mother of one child, has used homeopathy for herself and her child for 16 months)

As can be seen in this quotation, patients prefer homeopathy because, in contrast to biomedicine, homeopaths find the terms to intelligibly clarify their condition. In the homeopathic interview patients are asked about all sorts of

symptoms and personal traits, because symptoms are understood in a broad way. Homeopathy takes into consideration a *wide range* of mental, emotional and physical characteristics of patients. Beside their specific ailments, patients may be asked about preferred tastes, recurring dreams, greatest fears and many *details* about how and when their problems ameliorate or aggravate. Also, descriptions of symptoms are *nuanced* and homeopaths lead patients into a specific form of self-observation, in order to get the necessary information, rendering patients more active in the therapeutic relationship:

> And what is important is that she asks you things that an allopath would never ask. If you sweat or not at this kind of cold, if saliva draws from your mouth during the night, or not, how is your headache, on what side, is it heavy, is it sharp, is like a belt, is like a band, or who knows. There are all these nuances… and going to her for so long, I manage somehow to identify them and know clearly the answer to her questions.(Elena, mother of two children, has used homeopathy for herself and her family for five years)

It is not only that homeopaths have a more understandable vocabulary, but they also give explanations that are closer to patients' concerns. Since in homeopathy there is no interior specialisation for types of disorders; and mental, emotional and physical characteristics of the patients are taken into consideration when a remedy must be prescribed, the topics of the conversation may vary from talking about some specific physical symptoms to talking about the patients' work environment, or their family relations. How much time the doctors spend with them, how attentive they are to patients' concerns and how available they are in responding to patients' problems become criteria relevant in judging how a "good doctor" should be in the register of communication. Respondents often compare homeopaths to psychologists, suggesting that even though they go to a homeopath for a very specific physical complaint, their more general concerns will be taken in account.

Disguised monetary interests

When valuing medical care, patients also take into account the suspicion of disguised interests on the doctors' behalf. They can impute a commercial interest to conventional doctors and also to homeopaths, questioning their ethics and professionalism. This usually takes the form of what Boltanski and Thevenot (2006) call 'moments of unveiling' in the sense of unmasking false appearances when the worth of an object is disputed. In this way, respondents show their critical competence using linguistic operators like "in fact", "in reality" that mark a contrast between appearances, or what medical care should be, and what they consider to be the real intentions behind it:

> However, I think that their (conventional doctors) dermato-cosmetic recommendations are pure marketing, because you pay 50 or 100 lei for a cream that you use for one month, and why are you not prescribed one or another? Maybe because in fact they receive money? (...) There (a homeopathic clinic) they gave me a lot of remedies and the treatment cost about three million lei … well, they have their own pharmacy, they produce them, and that's probably why. (Ana, mother of one child, has used homeopathy for one year mainly for her child)

Some respondents talk about being judged by others as fools, because they give credit to a form of quackery in medicine and they pay money for "sham" remedies. This is emphasised also due to the fact that homeopathy is a private practice with no health insurance, and patients have to pay for treatments that would be completely covered by insurance from their general practitioner, in conventional medicine. As a response to this, homeopathic patients' accounts that portray homeopathy as a good form of medical are shaped as a justification for a choice that deserves their financial sacrifice:

> The consultation is not cheap but it is worth it. (Ina, mother of two children, has used homeopathy for herself and her family for 10 years)

In a certain sense, patients' accounts that evaluate medical care and treatment may be seen also contrasting private vs. public health care, voicing some of the more general critiques of the perceived deteriorating conditions of the public health system. The public hospital is presented as the last place where a patient would like to be, and any solution to avoid this may be worth a try. Added to this are also considerations that the so-called "free" public health care is not actually free, since various informal payments for doctors are considered unavoidable and largely normal (Stan 2012). What worries patients most is the interference of pharmaceutical companies in medical prescriptions. This is how this register intersects with an understanding of efficacy as a no-side-effects treatment. Patients see synthetic drugs not only as deficient objects through their negative side effects, but also as bearers of disguised financial interests.

DISCUSSION

Heuts and Mol's study regarding registers of valuing is oriented around a single object (a tomato), examining how different registers of valuing are used in different situations (Heuts and Mol 2013). They look at tensions between and within registers, and their argument is focused on studying values as performed in practice. Because they do not attend to who is doing the valuing, they leave aside

the fact that the same object (*e.g.* a homeopathic remedy) may be judged with the same register of valuing (*e.g.* efficacy) but may have different qualifications from different perspectives (*e.g.* biomedicine and homeopathy). As such, who is doing valuing work matters since this is an activity that may go beyond evaluating the object of concern through establishing different relationships between different worlds or domains.

Consequently, registers of valuing prove to be *a useful analytical tool for studying medical pluralism*. In this paper, I traced how patients who experience two therapeutic options choose among or combine them, justifying their choices in different registers of valuing that are based on criteria often used for assessing medical care. Any patient could employ them, for any therapy, and their generality works as a warrant for respondents' justifications, given that they must account for using a frequently critiqued form of medicine. Patients often compare homeopathy and biomedicine by appealing to *contrasts*, *successions*, and *continuities*. The contrast between homeopathy and biomedicine is reiterated and reinforced throughout all the four regimes, often taking the form of an opposition between good and bad medical care and treatment. On the one hand, scientific reports contrast biomedical drugs with homeopathic remedies and evaluate the latter as deficient, based on a criterion of efficacy understood in the terms of RCT trials. On the other hand, patients contrast biomedical drugs with homeopathic remedies based on a criterion of efficacy understood in terms of their own experience of healing, and the importance of no side-effects. It is not only a difference between the understanding of efficacy that separates the two versions of medicine. It is also the fact that medical care and treatment comprise, for patients, more elements than an RCT takes into consideration, and this can be seen in the relationships between the four regimes of values.

Patients' accounts of medical experiences have *a temporal structure that presents a succession between biomedicine and homeopathy*. In this, patients usually state a form of criticism of biomedicine (something went wrong in one or more registers of valuing) and justify in this way their choice for homeopathy. But this is seldom a *rupture* and it implies rather various forms of *continuities* between the two medical versions: either through the dual professional competence of the homeopath or through the various routes that patients take between the two (*e.g.* doing medical analyses and presenting them to their homeopath, or taking also a biomedical treatment prescribed by a conventional doctor).

In this way, relationships between homeopathy and biomedicine are not as clear-cut as Thomas Csordas (2006) suggests in his discussion of medical pluralism. As can be seen from respondents' accounts, this kind of relationship may vary from one situation to another, or depending on the aspects taken into consideration. Since homeopathy depends on some biomedical practices to achieve a form of healing and homeopaths are medical doctors, the two versions of medicine present continuities under what Csordas see as coordination, co-existence

and complementarity. The differences are rather revealed when the two versions are put in a relationship of contrast, or contradiction in Csordas' terms. But this contrast, at least from patients' perspective, is not built around incompatibility between the two versions of medicine, but rather on which therapeutic option seems a better one, relying on generally accepted registers of valuing.

Csordas's distinction takes into account relationships between forms of treatment based on how these options address a health problem, ignoring the temporal relationship between them. As I showed in discussing patients' accounts of routes between the two versions of medicine, *temporal succession plays an important role in giving meaning to their health experiences*. Since efficacy as a restoration of a desirable health state is one of the main criteria for evaluating medical treatments, patients will move from one option to another in their quest to find a solution to their problem. This originates from patients' pragmatism in their therapeutic options, an attitude amply documented by previous studies of CAM users and medical pluralism (Broom and Tovey 2008; Fadlon 2004; Last 2007). Nevertheless, patients also appeal to a *half-articulated normative philosophy of medical care and treatment* when they justify their options in terms of efficacy, understood as a no-side-effects treatment, and when they mobilize the other registers of valuing.

Acknowledgements

Many thanks to Cosima Rughiniş for important suggestions and careful reading of different versions of this paper. I am also indebted to the two anonymous reviewers of an earlier version for their constructive critique that contributed in giving shape to this paper.

REFERENCES

BARRY, A. C. (2006). Pluralism of Provision, Use and Ideology: Homeopathy in South London. In H. Johannessen & I. Lazar (Eds.), *Multiple Medical Realities. Patients and Healers in Biomedical, Alternative and Traditional Medicine*. New York and London: Bergham Books.89–104

BOLTANSKI, L. THEVENOT, L. (2006). *On Justification. Economies of Worth*. Princeton and Oxford: Princeton University Press.

BORLESCU, A. M. (2011). Being a homeopath. Learning and practice in a homeopathic community. *Journal of Comparative Research in Anthropology and Sociology*, *2*(2), 11–31.

BROOM, A. (2009). Cancer Patients' Accounts of Negotiating a Plurality of Therapeutic Options. *Qualitative Health Research*, *19*(8), 1050–1059.

BROOM, A. TOVEY, P. (2008). Exploring the temporal dimension in cancer patients' experiences of nonbiomedical therapeutics. *Qualitative Health Research*, *18*(12), 1650–61.

CAMPBELL, A. (2013). *Homeopathy in perspective. A critical approach*. Anthony Campbell.
CANT, S. SHARMA, U. (1995). The Reluctant Profession – Homeopathy and the Search for Legitimacy. *Work, Employment & Society*, *9*(4), 743–62.
CANT, S. SHARMA, U. (1999). *A New Medical Pluralism? Complementary Medicine, Doctors, Patients and the State* (Vol. 53). London: UCL Press.
CICOUREL, A. V. (1981). Language and the Structure of Belief in Medical Communication. *Studia Linguistica*, *35*(1–2), 71–85.
CSORDAS, T. (2006). Preface. In H. Johannessen & I. Lazar (Eds.), *Multiple Medical Realities. Patients and Healers in Biomedical, Alternative and Traditional Medicine*. New York and Oxford: Berghahn Books.ix–xi
DEGELE, N. (2005). On the Margins of Everything: Doing, Performing and Staging Science in Homeopathy. *Science, Technology & Human Values*, *30*(1), 113–136.
DUSSAUGE, I. HELGESSON, C.F. LEE, F. WOOLGAR, S. (2015). On the omnipresence, diversity, and elusiveness of values in the life sciences and medicine. In I. Dussauge, C.-F. Helgesson, & F. Lee (Eds.), *Value Practices in the Life Sciences and Medicine*. Oxford: Open University Press.1–30
ERNST, E. (2002). A systematic review of systematic reviews of homeopathy. *British Journal of Clinical Pharmacology*, *54*(6), 577–582.
FADLON, J. (2004). Unrest in Utopia: Israeli patients' dissatisfaction with non-conventional medicine. *Social Science and Medicine*, *58*(12), 2421–2429.
FIRESTONE, W. A. (1993). Alternative arguments for generalizing from data as applied to qualitative research. *Educational Researcher*, *22*, 16–23.
FRANK, R. (2002). Integrating homeopathy and biomedicine: medical practice and knowledge production among German homeopathic physicians. *Sociology of Health & Illness*, *24*(6), 796–819.
FRANK, R. ECKS, S. (2004). Towards an ethnography of Indian homeopathy. *Anthropology & Medicine*, *11*(January 2012), 37–41.
FRANK, R. STOLLBERG, G. (2006). German Medical Doctors' Motives for Practicing Homeopathy, Acupuncture, and Ayurveda. In H. Johannssen & I. Lazar (Eds.), *Multiple Medical Realities. Patients and Healers in Biomedical, Alternative and Traditional Medicine*. New York and Oxford: Bergham Books.72–88
FRANKEL, R. M. (1995). Some Answers About Questions in Clinical Interviews. In G. H. Morris & R. J. Chenail (Eds.), *The Talk of the Clinic. Explorations in the Analysis of Medical and Therapeutic Discourse*. New York and London: Routledge. Taylor & Francis Group.233–258
GALE, N. (2014). The Sociology of Traditional, Complementary and Alternative Medicine. *Sociology Compass*, *8*(6), 805–822.
HARRELL, S. (1991). Pluralism, performance and meaning in Taiwanese healing: A case study. *Culture, Medicine and Psychiatry*, *15*(1), 45–68.
HERITAGE, J. MAYNARD, D. W. (2006). Introduction: Analyzing interaction between doctors and patients in primary care encounters. In J. Heritage & D. W. Maynard (Eds.), *Communication in Medical Care. Interaction between Primary Care Physicians and Patients*. Cambridge University Press.1–21
HEUTS, F. MOL, A. (2013). What Is a Good Tomato? A Case of Valuing in Practice. *Valuation Studies*, *1*(2), 125–146.
HSU, E. (2008). Medical Pluralism. In K. Heggenhougen & S. Quah (Eds.), *International Encyclopedia of Public Health: J-O*. Amsterdam: Elsevier.316–321

JOHANNSSEN, H. (2006). Introduction. Body and Self in Medical Pluralism. In H. Johannessen & I. Lazar (Eds.), *Multiple Medical Realities. Patients and Healers in Biomedical, Alternative and Traditional Medicine*. New York and Oxford: Bergham Books.1–20

JOHNSTONE, B. (2008). *Discourse Analysis*. Malden, Oxford and Victoria: Blackwell Publishing.

JONAS, W. B. KAPTCHUK, T. J. LINDE, K. (2003). A critical overview of homeopathy. *Annals of Internal Medicine*, *138*(5), 393–399.

LAST, M. (2007). The Importance of knowing about not knowing. In R. Littlewood (Ed.), *On Knowing and Not Knowing in Anthropology of Medicine*. Walnut Creek, CA: Left Coast Press.1–17

LINDQUIST, G. (2002). Healing efficacy and the construction of charisma: A family's journey through the multiple medical field in Russia. *Anthropology & Medicine*, *9*(3), 337–358.

MILGROM, L. R. (2006). Is homeopathy possible? *The Journal of the Royal Society for the Promotion of Health*, *126*(5), 211–218.

MOL, A. MOSER, I. POLS, J. (2010). Care: putting practice into theory. In A. Mol, I. Moser, & J. Pols (Eds.), *Care in Practice. On Tinkering in Clinics, Homes and Farms*. Bielefeld: Transcript. 7–26

OBERBAUM, M. SINGER, S. R. VITHOULKAS, G. (2005). The colour of the homeopathic improvement: The multidimensional nature of the response to homeopathic therapy. *Homeopathy*, *94*(3), 196–199.

SHARMA, U. (1992). *Complementary medicine today. Practitioners and patients*. London: Routledge.

SHARMA, U. (1993). Contextualizing alternative medicine: The exotic, the marginal and the perfectly mundane. *Anthropology Today*, *9*(4), 15–18.

SMITH, D. E. (1978). `K is Mentally Ill' the Anatomy of a Factual Account. *Sociology*, *12*(1), 23–53.

STAN, S. (2012). Neither commodities nor gifts: Post-socialist informal exchanges in the Romanian healthcare system. *Journal of the Royal Anthropological Institute*, *18*(1), 65–82.

STARK, D. (2009). Heterarchy: The Organization of Dissonance. In *The Sense of Dissonance. Accounts of Worth in Economic Life*. Princeton and Oxford: Princeton University Press.1–34

WAHLBERG, A. (2007). A quackery with a difference-New medical pluralism and the problem of "dangerous practitioners" in the United Kingdom. *Social Science and Medicine*, *65*(11), 2307–2316.

WALACH, H. (2003). Entanglement model of homeopathy as an example of generalized entanglement predicted by weak quantum theory. *Forschende Komplementarmedizin Und Klassische Naturheilkunde*, *10*(4), 192–200.

WHITEFORD, M. B. (1999). Homeopathic medicine in the city of Oaxaca, Mexico: patients' perspectives and observations. *Medical Anthropology Quarterly*, *13*(1), 69–78.

SOCIO-ECONOMIC STATUS AND WOMEN'S HEALTHCARE UTILIZATION: A STUDY OF SELECTED AREAS INNIGERIA

JEMISENIA JOHN OLUWASEYI[1],
EZENAGU NNEDINMA ROSELINE[2], ADEJOH AROME[3]

ABSTRACT

Literature bordering on women's health care utilization in relation to their socio-economic status (SES) and other socio-cultural factors abound. However, while these studies have been carried out in different places across the globe under varying social conditions, and particularly on maternal mortality and morbidity issues, little is still known about the effects of SES on women's health care utilization in Nigeria. Consequently, this study described women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State, Nigeria. By means of a probability multistage cluster sampling procedure and a purposive sampling method, we selected five hundred and ninety two respondents for the survey and sixteen respondents for the Focus Group Discussions. Following analyses of data, it was revealed that education, occupation and income impact on women's decision, quality of treatment, frequency of visits to the hospital, length and duration of hospital stay, time of visits to the hospital, and the type of health facilities visited. Also, the women in the study sample reported that they utilize health care services most frequently during the incidences of chronic disease like hypertension, diabetes, etc in the past six months compared with other incidences of illnesses and diseases. The study therefore recommends that women's socio-economic standing must be improved by workable policies that are aimed at improving their chances in the socio-economic ladder in order for them to fully maximize the opportunities inherent in the utilization of health care services.

Keywords: *health care, women's health, utilization, Nigeria, socio-economic status.*

[1] Medical Sociology, Department of Sociology and Anthropology, University of Nigeria Nsukka, Nigeria. Email: jonny2005ng@yahoo.com

[2] Medical Sociology, Department of Sociology and Anthropology, University of Nigeria Nsukka, Nigeria. Email: roselineezenagu@gmail.com

[3] Criminology, Department of Sociology and Anthropology, University of Nigeria Nsukka, Nigeria. Email: arome1015@gmail.com

Rom. Jour. of Sociological Studies, New Series, No. 1, p. 25–48, Bucharest, 2017

(cc) BY-ND

Creative Commons License
Attribution–NoDerives CC-BY-ND 4.0

INTRODUCTION

This study attempted to describe women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State, Nigeria. Literature bordering on women's health care utilization in relation to their socio-economic status (SES) and other socio-cultural factors abound, however, while these studies have been carried out in different places across the globe under varying social conditions, and particularly on maternal mortality and morbidity issues, little is still known about the effects of SES on women's health care utilization in all illness episodes in Nigeria. Although, some scholars (e.g., Currie, 2005; Hulka and Wheat, 1985; Owens, 2008; Redondo-Sendino, Guallar-Castillon, Banegas, and Rodriguez-Artalejo, 2006) have argued that women utilize health care services more than men, the question of whether the level of service is adequate to women's need is less clear, yet others (e.g., Coimbra et al., 2007; Owens, 2008; Pillai et al., 2003) have maintained that the quality and the levels of women's health care utilization is largely dependent on their SES and other socio-cultural factors, which influences them.

The relationship as well as the effects of SES on women's health care utilization has been investigated in a number of studies. For example, studies (e.g., Azuh, Fayomi and Ajayi 2015; Bredensen, 2013; Chakraborty, Islam, Chowdury, Bari, and Akhter, 2003; Halle-Ekane, et al., 2014) have found that women's level of education has a significant effect on their health care utilization. As opposed to the foregoing, Ochako, Fotso, Ikamari, and Khasakhala's (2011) in a cross-sectional study conducted in Kenya, found a seemingly counter-intuitive effect of education on early antenatal utilization. However, fewer sub-Saharan African studies examining the effect of education on utilization exist; those that do, find that the relationship between educational status and health care utilization is not simple; (Swedo, 2012) thereby making the understanding of the effects of education on health care utilization a complex one.

Regarding women's level of occupation and its effects on health care utilization, Shah and Belanga (2011) found out in their study that women who work are less likely to utilize health care services during illness episode–a contrasting discovery to evidences from other studies (Bredensen, 2013; Redondo-Sendino et al., 2006)–showing that the level of healthcare utilization increases as women advance in their line of work (career). Yet studies like that of Mamurnur and Antai (2014) have found the effect of occupation on health care utilization to be inconclusive. As for income, studies (e.g., Buor, 2003; Mackenbach and Howden-Chapman, 2003; Månsdotter, 2006; Taffa and Chepngeno, 2005) have revealed that women's level of income positively influence their level of health care utilization, while other studies from the developing countries have found negative effects of income on women's health care utilization (Geda and Shimeles, 2009; Mwabu, 2009). To this end, several studies have attempted to examine the

effects of education, occupation and income on women's health care utilization. In finding out these effects however, there exist contrasting evidences as to the impacts of these variables on health care utilization. As a result, the effects of education, occupation and income on women's health care utilization are poorly understood and thus may have a serious implication for intervention programme and policy recommendation.

As for the study areas of this research endeavour, Lokoja and Dekina LGAs of Kogi State, there is a dearth of literature on the levels of health care utilization by women. Even though very few studies (e.g., Akandeand Owoyemi, 2009; Eze and Adhure, 2014) have identified the importance of education, income and other socio-cultural factors (that are peculiar to women in these areas) influencing health care services such as family planning and other health challenges, none of these studies have measured health care utilization by women and none has also examined the effects of SES on health care utilization. This situation reflects a huge epistemological and methodological gap and therefore deserves a pressing investigation.

Nevertheless, although literature that are foreign to the social cultural experiences of Lokoja and Dekina women abounds on SES, local research examining its effects on health care utilisation in Lokoja and Dekina is almost non-existent. This present study is therefore designed to achieve the following: (1) determine the level of health care utilization by women in Lokoja and Dekina Local Government Areas of Kogi State; (2) examine women's beliefs about the effects of their educational, occupational and income levels in the utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State. It is also imperative to note that knowledge of the effects of SES on the utilization of healthcare by women in Lokoja and Dekina LGAs is valuable for improving intervention programmes aimed at enhancing the quality of healthcare use, and can help to inform the decision-making of policy-makers on women's health. In all, the statement of the problem of this study put in form of a question is: "What are the perceived effects of SES on health care utilization by women in Lokoja and Dekina LGAs of Kogi State?"

THEORETICAL BACKGROUND

The behavioral model of health (BM) as propounded by Andersen M. R. in 1968 is most valuable in the understanding of the perceived effects of socio-economic status in the utilization of health care services by women (see for discussion Majaj, Nassar and Allegri, 2011), and because it is widely documented and used to determine predictors of access to health care (Hogan et al., 2012), it was applied to the study. The BM is hinged on the following assumptions:

- **Predisposing factors:** these includes demographic characteristics of gender, marital status, age and sex as biological necessaries; social factors such as education, occupation ethnicity and social relationships (e.g., family status), and mental factors in terms of health beliefs (e.g., attitudes, values, and knowledge related to health services and health).
- **Enabling Factors:** these include financing factors such as income and wealth at individuals' disposal, which enables them to pay forhealth services and the effective price of health care or the quality of health care; which is determined by individuals' health insurance status. Financing here covers per capital income, affluence, the rate of health insurance coverage among others.
- **Need factors:** at the individual level Andersen and Newman (1973) differentiate between perceived need and evaluated need. The perceived needinclude how people view and experience their own general health, functional state and illness symptoms. And evaluated need refers to professional assessment and objective measurement of patients' health status and need for medical care.

This model identifies education and occupation as one of the factors under the predisposing characteristics that determine the use of health care access and utilization. These demographic positions according to Andersen equip individuals' belief and consequent utilization of health services (Rebhan, 2008) – this part carefully delineates the vantage point that education and occupation occupy in the life of women as they utilize health care services. Also, income as part of the key variables in the study, falls in the second category (enabling characteristics) upon which health care utilization is premised as it includes resources found within the community and the family (Rebhan, 2008) – here income has the capability of directing not only where health care is available but the quality of health care services utilized by women. The need based characteristics also includes the perception of needs for health services which leads to the actual utilization of health care services.

METHODOLOGY

Research Design

A cross-sectional, descriptive survey and exploratory qualitative methods were employed in eliciting data for this study. Survey is often a suited method for descriptive, explanatory and exploratory purpose (Babbie, 2013; Bhattacherjee, 2012; Haralambos and Holborn, 2013) and hence this study described women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State.

Additionally, qualitative exploratory method was considered appropriate for the study (see Babbie, 2013; Shank, 2002 for discussion).

The study areas for this research are Lokoja and Dekina Local Government Areas of Kogi State. Lokoja with an estimated land mass of 3243.323 sq. km (National Population Census, 2010) is located between latitudes $7^0 46'$ N - 7^0 52^1 and longitudes 6^0 $38'$ E- 6^0 46' and shares boundaries with Kabba-Bunnu, Okehi, Adavi, Kogi, Ajaokuta and Bassa LGAs of Kogi State (NPC, 2010). Lokoja has one federal public tertiary health facility, seven public state secondary health facilities, 26 Primary Health Centre (PHC) and 25 private health facilities making a total of 59 health facilities. The choice for this area was influenced by the fact that majority of the women play significant role in the economic activities of the area as traders, civil servants, teachers, health workers and so forth.

The second area of this study, Dekina LGA, falls between latitude 6^0.33' and 8^0.44', and longitude 5^0.22' and 7^0. 49' (Adejo, Idoka and Adejo, 2013). Dekina shares boundaries with Ofu, Olamaboro, Anpka and Omala LGAs of Kogi State (NPC, 2010). Also Dekina has seven public state secondary health facilities, 100 PHCs and 15 private health facilities, totaling 122. The choice for this area was influenced by the fact that a preponderance of women play essential and dynamic roles in the rural economies of the area, being actively involved as small scale farmers who engage in crop (such as yam, maize, cocoa yam, cashew and palm oil production) and animal production for domestic and commercial purposes, traders, teachers and so on. The population of this study is given as the 225, 072 working women, aged 18 years and above in the study areas.

Sample Size and Sampling Procedure

The sample size for this study was 601.With 95 percent level of confidence (confidence interval-$\pm$ 10%), an estimated level of health utilization by women at 50% (.5) and a permitted margin of error at .04 (4 percentage points), we determined the 601 sample size with the Cochran (1963, 75) formula:

$$n = \frac{[Z/_2]^2\ (p\,q)}{e^2} \quad n = \frac{[Z/_2]^2\ (P)\ (1-P)}{e^2}$$

Where: n = sample size, Z^2 = confidence level, p= rate of occurrence or prevalence (the estimated proportion of an attribute that is present in a population), q= complement of p and e= margin of error. Therefore;

$$n = \frac{[1.96]^2\, 0.5\ (1-0.5)}{0.04^2} \quad n = \frac{3.8416\ (0.25)}{0.0016n = 600.25. = 601.}$$

Furthermore, a proportional stratified sampling method of each population was employed for a possible modification of the 601 sample size above. The stratification variable here was geographical location.

Table 1

A proportionate stratified sampling for Lokoja and Dekina LGAs

Geographical Location	Population	Proportionate Stratified		
Lokoja	95498	42.4	255	42.4
Dekina	129574	57.6	346	57.6
Total	225072	100	601	100

Source: Survey (2016)

It should be noted that of the entire 601 questionnaires that were administered to respondents in both Lokoja and Dekina Local Governments areas of Kogi State, 592 (98.50%) were returned. The 592 respondents and the 16 other FGD participants served as the final source of data for the study. At this point, we adopted a probability multistage cluster sampling procedure. The reason for this was because of the unavailability of a sampling frame that contains the lists of women in the areas of study hence the technique is best suited for this circumstance as Babbie (2013, 153) succinctly averred that multi-stage cluster sampling "may be used when it's either impossible or impractical to compile an exhaustive list of elements composing the target population." This was a three stage sampling approach. We began the first stage by stratifying Lokoja and Dekina LGAs on the basis of residential differences, dividing the two areas into 31and 24 residential zones respectively.

At the second stage, we employed a systematic sample with a random start to select a sub sample of 5 residential zones in Lokoja and 7 residential zones in Dekina (making 12 zones in all). The justification for the chosen numbers was to encourage adequate representation in the two areas. In doing this, we selected randomly one zone from each frame after which every Kth (i.e., every 6th and 3rd respectively) (where sampling interval, $K = N/n$) elements (zones) were systematically selected. From the 12 zones that were systematically selected, the third stage began. This kick-started with a design of a workable list of households out of the 12 zones that were selected and subsequently, 50 households each were selected by a means of simple random sampling, from each of the 12 zones. This amounted to 600 households in all (one household was also purposively added from Ajara residential zone in Lokoja). In the end, each of the households that were selected produced women sampled respondents for the study in the two areas.

As for the other sample size (16 women) who served as participants in the FGDs, the selection technique adopted was a non-probability purposive sampling. Eight participants (4 with a skilled occupation and the other 4 with unskilled occupation) were selected in both areas of study based on the following inclusion criteria: (1) ownership of at least some primary school education or skilled in trading (2) have a job or profession (3) earn some form of income (4) willingness to participate and (5) an indigene of Kogi State.

Instrument for Data Collection

A semi-structured questionnaire instrument of two sections was employed for the present study. We also employed scales and measurement tests as a supplementary tool for this study. In this case, the we adapted a self-reported Stanford Patient Education Research Center Health Utilization Scale ("SPERCHUS") developed by Lorig et al. (1996) which was modified into a 13 item scale and was included in the second section of the questionnaire instrument. The internal consistency of the "SPERCHUS" was conducted in order to ascertain the reliability of the scale. Cronbach's alpha (α) for the "SPERCHUS" items was .96 (96 percent) and was found to be highly reliable. As for the qualitative aspect, the focus group discussion (FGD) guide was employed to elicit data from participants. The guide contained the purpose for the study, ground rules for participants and open ended questions that guided the discussions in both areas of study.

Administration of Instruments

In the administration of the questionnaire instrument, we specifically trained six volunteers (on data administration process), while three of them (residents of Dekina LGA) helped in the distribution of questionnaire to respondents in Dekina, the remaining three (residents of Lokoja LGA) helped in the distribution of questionnaire to respondents in Lokoja area. Under our supervision, this stage of the research endeavor lasted for a period of 2 weeks and the first three days were slated for distribution and retrieval of questionnaire in Dekina from Monday to Wednesday (from 10am to5pm). Meanwhile questionnaires that could not be retrieved within this three day period later retrieved within the following days (Thursday to Saturday) within the same time frame. Next, within the same 6 day period and time frame of the second week, volunteers in Lokoja under the supervision of the researchers undertook the exact process that was carried out in Dekina LGA in the previous week.

Also, a combination of two FGDs was conducted in the areas of study. The FDG sessions took place in both areas of study and thus comprised of eight women (4 with a skilled occupation and the other 4 with unskilled occupation) each in both areas of study. The discussions were held in public places that were approved by selected participants in both areas of the study.

Method of Data Analysis

A combination of quantitative and qualitative methods of data analysis was used for this study. We utilized an interpretative phenomenological analysis (IPA). The aim of this tool according to Smith and Osborne (2007) is to "explore in detail how participants are making sense of their personal and social world" (53). This design was employed due to its capacity of eliciting in-depth understanding of the research topic. In order to identify themes from the data that were collected, key words and phrases, repetition of concepts and ideas (recurring ideas), indigenous

categories, and metaphors and analogies (Ryan and Bernard, 2003) were employed. Furthermore, descriptive statistics was used to describe women's beliefs about the effects of socio-economic status in their utilization of health care services in the study areas. Specifically, simple percentages and central tendency measures were employed. Graphs and charts were also used to describe some aspects as they are best suited for visual representation. These two methods of data analysis complemented each other at this stage of the research work.

RESULTS

Health Care Utilization by Sample of Women in the Study Areas

Table 2

Health Care Utilization by Sample of Women in Lokoja and Dekina Local Government Areas of Kogi State

S/N	Level of Health care Utilization (n/%)	N	M(SD)	95%CI
1	**Minor illnesses like headache or cold** 0=never 139 (23.5%) 1=once 204 (34.5%) 2=twice 111(18.8 %) 3=three times 73(12.3%) 4=four times 45(7.6%) 5=five times and more 20(3.4%)	592	1.56(1.35)	[1.45, 1.67]
2	**Injury** 0=never 152 (25.7%) 1=once 171 (28.9%) 2=twice 99 (16.7%) 3=three times 105 (17.7%) 4=four times 43 (7.3/%) 5=five times and more 22 (3.7%)	592	1.63(1.41)	[1.52, 1.75]
3	**Menstrual related problems like stomach ache, etc** 0=never 239 (40.4%) 1=once 193 (32.6%) 2=twice 72 (12.2%) 3=three times 53 (9.0%) 4=four times 17 (2.9%) 5=five times and more 18 (3.0%)	592	1.10(1.27)	[1.00, 1.21]
4	**Chronic disease like hypertension, diabetes, etc** 0=never 13 (2.2%) 1=once 81(13.7%) 2=twice 102 (17.2%) 3=three times 108 (18.2%) 4=four times 110 (18.6%) 5=five times and more 178 (30.1%)	592	3.28(1.49)	[3.15, 3.39]

5	**Clinical tests for breast lumps or ovarian, cancer, etc.** 0=never 341 (57.6%) 1=once 127 (21.5%) 2=twice 61 (10.3%) 3=three times 48 (8.1%) 4=four times 12 (2.0%) 5=five times and more 3 (.5%)	592	.77(1.10)	[.68, .86]
6	**Check ups** 0=never 162 (27.4%) 1=once 229 (38.7%) 2=twice 67 (11.3%) 3=three times 108 (18.2%) 4=four times 8 (1.4%) 5=five times and more 18 (3.0%)	592	1.37(1.26)	[1.26, 1.47]
7	**Depression** 0=never 187 (31.6%) 1=once 202 (34.1%) 2=twice 96 (16.2%) 3=three times 53 (9.0%) 4=four times 18 (3.0%) 5=five times and more 36 (6.1%)	592	1.36(1.39)	[1.25, 1.47]
8	**Family planning** 0=never 159 (26.9%) 1=once 207 (35.0%) 2=twice 108 (18.2%) 3=three times 56 (9.5%) 4=four times 37 (6.2%) 5=five times and more 25 (4.2%)	592	1.46(1.36)	[1.35, 1.57]
9	**Pregnancy related visits (e.g., antenatal visits or complication, etc)** 0=never 203 (34.3%) 1=once 156 (26.4%) 2=twice 90 (15.2%) 3=three times 85 (14.4%) 4=four times 26 (4.4%) 5=five times and more 32 (5.4%)	592	1.44(1.46)	[1.33, 1.56]
10	**Medication visits and hospital admission** 0=never 136 (23.0%) 1=once 146 (24.7%) 2=twice 93 (15.7%) 3=three times 94 (15.9%) 4=four times 80 (13.5%) 5=five times and more 43 (7.3%)	592	1.94(1.59)	[1.81, 2.07]
11	**Surgery related visits** 0=never 158 (26.7%) 1=once 158 (26.7%) 2=twice 130 (22.0%) 3=three times 45 (7.6%) 4=four times 77 (13.0) 5=five times and more 24 (4.1)	592	1.66(1.48)	[1.54, 1.78]

12	**Visits for eye problems** 0=never 310 (52.4%) 1=once 166 (28.0%) 2=twice 65 (11.0%) 3=three times 30 (5.1%) 4=four times 9 (1.5%) 5=five times and more 12 (2.0%)	592	.81(1.12)	[.72, .91]
13	**Visits for oral health problems** 0=never 253 (42.7%) 1=once 156 (26.4%) 2=twice 85 (14.4%) 3=three times 57 (9.6%) 4=four times 22 (3.7%) 5=five times and more 19 (3.2%)	592	1.15(1.34)	[1.04, 1.26]

Source: Survey (2016)

Note. CI= confidence interval, M=mean, SD=standard deviation, N=Total number of sample, n (%) =sub-sample of items and percentages.

Percentages and Measures of central tendency were computed to summarize the data for the self-reported health care utilization by a sample of women in the areas of study. Result from Table 2 revealed that majority of the women in the study sample reported that they utilize health care services most frequently during incidences of chronic disease like hypertension, diabetes, etc. in the past six month. On the other hand, regarding health issues such as illnesses and cold, injury, menstrual related problems like stomach ache, etc., check-ups, depression, family planning, pregnancy related visits (e.g., antenatal visits or complication, etc.), medication visits and hospital admission, surgery related visits, and visits for oral health problems, the self-reported health care utilization scores showed that women visit less frequently for the aforementioned reasons. Additionally, health behaviors like clinical tests for breast lumps or ovarian, cancer, etc., and visits for eye problems had the lowest score on the health care utilization scale by women. This result indicates that in the past six month, women in the study areas mostly do not utilize health care services during experiences of most health issues except during incidences of chronic disease like hypertension, diabetes, etc. This may partly be due to the fact that such health conditions as diabetes and hypertension are perceived as life threatening and can also serve as risk factors for more severe chronic and acute disorders, hence the women’s high score on the health care utilization scale.

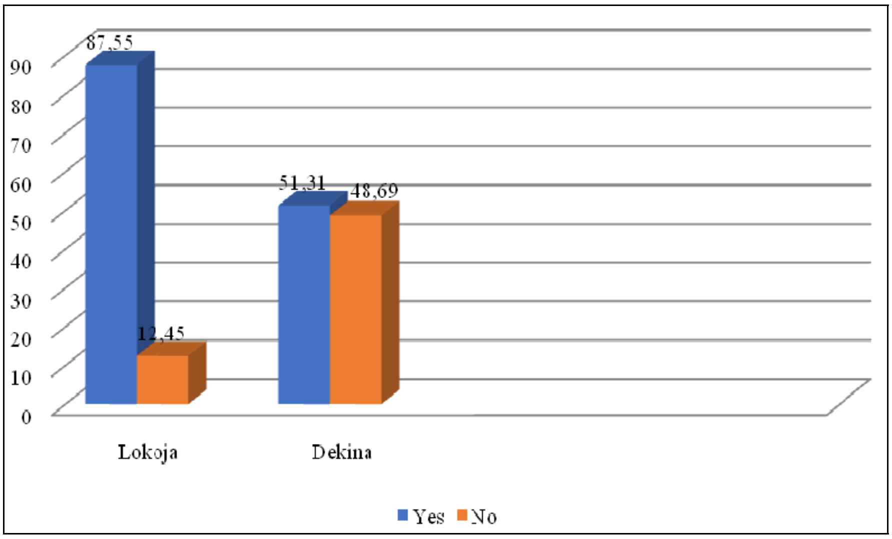

Figure 1. Women's Belief on the Influence of Educational Levels on Their Use of Health-Care.
Source: Survey (2016)

As shown in Figure 1, respondents were asked whether they believe that their level of education can influence the way they use health care services, 87.55% of women in Lokoja and 51.31% of women in Dekina affirmed that they believe that their level of education can influence the way they use health care services. On the contrary however, 12.45% in Lokoja and 48.69% in Dekina believe otherwise. This result suggests that more women in Lokoja than Dekina believe that education could impact on health care utilization of women. On the whole, this result (Figure 1) is indicative of the fact that a preponderance of women in the study area sees a linkage between their educational levels and health care utilization.

In order to further test the ways in which education can influence women's use of health care services during sickness in the study areas, a multiple response question was attempted by the sample of women who believe that the level of education can affect health care utilization. Table 3 shows the distribution of respondents via ways in which education can influence health care utilization by women in the study areas.

A thorough look at this list of multiple items (see Table 3) reveals that the quality of treatment appeared in almost all the categories of items that were provided. Therefore, this suggests that the quality of health care use is closely understood, by the respondents, as a product of women's level of education. As for respondents who gave other ways in which educational levels influence health care utilization, a further assessment of their choices reveals that cost, insurance, demand for certain kind of treatment at the hospital, the course of redress when and after women's right have been abused in the hospital and perception of women (patients) who utilize health care services are important.

Table 3

Distribution of Respondents by the Ways in which Women's Level of Education Can Influence Their Use of Health Care Services.

	Multiple Items Chosen by Respondents	Lokoja(%)	Dekina(%)	Total(%)
1	Decision to go or not to go, Frequency of Visits, Time of Visits, quality of treatment and "others"	32(14.68)	40(22.73)	72(18.3)
2	Frequency of visits, decision to go or not to go, time of visits, and quality of treatment	53(24.31)	30(17.05)	83(21.1)
3	Time of visits, quality of treatment, and "others"	44(20.18)	25(14.20)	69(17.5)
4	Quality of treatment, and frequency of visits	48(22.02)	27(15.34)	75(19.0)
5	"Others" and quality of treatment	27(12.39)	35(19.89)	62(15.7)
6	I can't really say	14(6.42)	19(10.79)	33(8.4)
	Total	218(100)	176(100)	394(100)

Source: Survey (2016)

In reaffirming these findings, a FGD participant in Dekina LGA noted that:

> Education is very crucial to how women view their bodies, illnesses and disease which in turn determines how well women visit the hospital and most importantly, the quality of hospital visits. By quality, I mean having the ability to always ask questions for clarification and avoiding complications that may be caused by ignorance (female, 27 years, Nurse in Dekina Local Government Area).

This position as given by this participant suggests the vital role education can play in informing the perception women have about their body as well as frequency and quality of health care services. This quality as defined by the participants is what Andersen, Rice, and Kominski (2007) refer to as the *effective price of health care*. In other words, quality refers to the process of getting in return more or the exact amount of health care that is being paid for. This according to the data from this participant can be influenced by women's level of education. Although, Andersen's work linked income with quality of health care, the present study also finds a perceived link between education and quality of health care.

However, there was a counter-intuitive opinion from a FGD participant in Lokoja LGA who expressed her personal view that education means nothing to a woman. By means of interpretative phenomenological analysis (IPA), a theme of surrounding "gender and education in health" emerged. Specifically, she shares a perspective that:

> Whether women are educated or not, there are strong socio-cultural factors which make the purpose of education in this direction useless, most especially for married women. It is as if we hang our thinking caps to our husbands only as decisions regarding hospital visits for any reason must be

> sanctioned or approved by the men. For me personally, I can only visit the hospital whenever my husband is around; if he travels or anything, I stay at home no matter how serious it is(female, 41 legal practitioner, Lokoja LGA).

Another participant then corroborated this perspective by narrating a personal experience:

> I sustained a skin burn by boiling water recently and as a result I did not allow anyone to take me to the hospital until my husband came. So, it is not about how educated I am; I have been trained from time not to take such decisions without my husband's approval or presence(female, 22 years, senior secondary school certificate, and trader in Lokoja LGA).

The opposing responses given above are indicative of the fact that the level of a woman's education does not lead to corresponding health care utilization. In other words, beyond whatever level of education one must have acquired, gender (i.e., being a woman) is a primary, superior and most importantly, a determinant of health care utilization. This perhaps explains why some social, biological and psychological experiences that come with womanhood are seen as conditions, in which women themselves are incapable of treating or taking care of, hence the emotional dependence on their husbands or any male figure in the household for health care utilization. It could therefore be argued that education within this context does little in empowering women to seek health care. This in the participants' view is caused by socio-cultural factors out of which marriage is key to the understanding of women's health care utilization and therefore not only makes the link between a woman's education and health care utilization unobservable, but also redundant. The position for instance confirms Swedo's (2012) assertion that the relationship between educational status and health care utilization is not simple within the sub-Saharan African context.

Just as in the previous Figure (1), Figure 2 shows whether women believe that the type of job or occupation by women can influence the use of health care services. Following analysis of the obtained data, it was revealed that a sheer majority of the entire respondents (89.56% of sampled women in Lokoja and 92.42% of sampled women in Dekina) are of the opinion that the type of job they do can influence their health care use. On the other hand however, the remaining respondents (10.44% of the sampled women in Lokoja as against 7.58% of the sampled women in Dekina) have a contrary view. The choice of the overwhelming majority leaning towards the affirmation that occupation type can influence health care utilization by women is suggestive of the fact that it (type of job) is particularly important in their daily lives and may therefore impact positively or negatively on the use of health care by women.

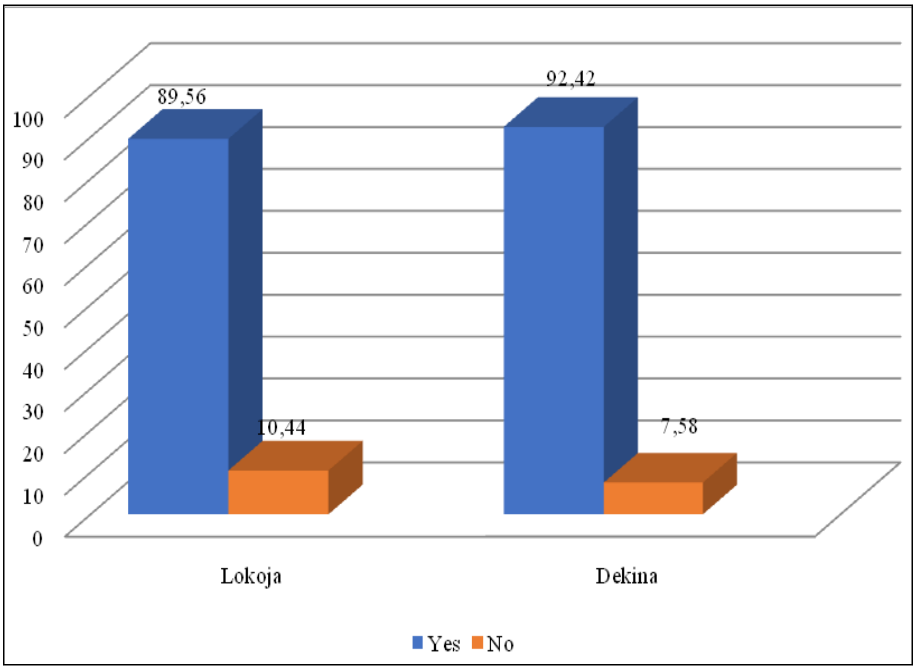

Figure 2. Distribution of Respondents By Belief That Women's Type of Job (Occupation) Can Influence the Way They Use Health Care Services.

Source: Survey (2016)

Table 4

Distribution of Respondents by the Ways in which Women's Type of Occupation Can Influence Their Use of Health Care Services.

	Multiple Items Chosen by Respondents	Lokoja(%)	Dekina(%)	Total(%)
1	Time of visit and treatment, Frequency of visits, Quality of treatment, and Length and duration of visits	43(19.28)	46(14.51)	89(16.5)
2	Length and duration of visits, Frequency of visits, quality of treatment	27(12.11)	88(27.76)	115(21.3)
3	Frequency of visits and "others"	92(41.26)	98(30.91)	190(35.2)
4	Quality of treatment and length and duration of visits	28(12.56)	52(16.40)	80(14.8)
5	"Others" and time of visit and treatment, and frequency of visits	32(14.35)	12(3.79)	44(8.1)
6	I can't really say	1(0.44)	21(6.62)	22(4.1)
	Total	223(100)	317(100)	540(100)

Source: Survey (2016)

In order to further test the ways in which types of job or category of occupation can influence women's use of health care services during sickness in the study areas, a multiple response question was attempted by the sample of women who believe that the type of occupation can affect health care utilization. Table 4 shows the distribution of respondents via ways in which occupation can influence health care utilization by women in the study areas.

From Table 4 above, it can be observed that respondents' most frequent view suggested a link between the types of occupation a woman engages in and the frequency of her hospital visits during illness episode. In other words, majority of the respondents attributed the number of times they visit the hospital to the nature of their jobs. Furthermore, we took a qualitative approach to understanding the perceived link between and effects of occupation on health care utilization. Consequently, the FGD participants in the study were divided in their views. While some believed that the type of occupation women engage in could influence their healthcare utilization, others had a contrary opinion. To this end, a FGD participant is quoted as saying:

> Today, women work outside the home. However, this new development does not take away the fact that women still work to keep the home either as a daughter, daughter in-law or as a wife and mother. These many responsibilities take a huge toll on women's health and personal time to seek healthcare. I know this because, as a mother, there are instances where you work round the clock and even when you are feeling sick, you still manage or hide the feelings so as to be able to take care of your kids and get back to work the next day (female, 48 years, primary school teacher in Dekina LGA).

Another FGD participant from Lokoja expressed her view thus:

> For certain kinds of very demanding job such as banking, or some other time taking jobs, women may not have time to go for checkups or even cater for their health. They only get a break once in a year. Except for conditions that are life threatening, women doing such jobs may not be able to use healthcare services well (female, 26 years, civil Servant with the federal government in Lokoja).

The response from this participant and others who share similar view describes how despite the transition between the times past where women had little or no opportunity to work outside the home to the present times where women have proven their capacity to handle responsibilities outside the home, the reality of being a girl-child or woman within the home increases the responsibilities of work place and therefore serves as a risk factor for illness episodes. However, this position (contrived life style) tends to push some women into a corner where they "fake" sound health or pretend that they are healthy all for the sake of their children. On the whole, this type of experience impacts significantly on the extent

or level of their healthcare utilization. For the majority of women who have this experience, they are most likely not to utilize health care services even if it is readily available.

Similarly, in the view of other participants, women who work outside their homes as professionals or who engage in time consuming jobs rarely have time to assess their bodies or health status subjectively; leading to little or no time to visit the hospital. In other words, this type or quality of job impacts negatively on women's health care utilization.

Taken from another perspective, participants believe that high paying jobs lead to a corresponding health care utilization. This can take place in two different dimensions. First, high paying jobs leads to high pay or salary, which eventually helps women (or anyone) to maintain good health or lead a disease preventive life style (e.g., good diet, exercise, regular medical checkup, etc.). Second, it leads to proper health care utilization during illness episode. Here, there is a perceived relationship between occupation (especially, professional or skilled types), income and health care utilization as Stevenson (cited in the American Psychological Association, 2007) posits that higher income provides access to goods and services such as health care, including mental health services. The expression of this FGD participant summarizes it all:

> Well I see it this way, if you have a good job and earn good money, you will live well and take good care of your body and there will be no need visiting the hospital and when in fact there is any need, you can afford it because you have a good job. In this manner, your type of occupation may have a lot to do with how well you visit the hospital and how well you are treated (female, 30 years, business woman and student in Lokoja LGA).

The sampled respondents were further asked to confirm whether income could influence women's healthcare utilization. Figure 3 therefore shows the distribution of respondents on this. While the majority (84.97%) of the entire respondents affirmed that indeed income could influence the ways in which women use health care services, the remaining (15.03%) respondents confirmed otherwise. Specifically, 93.98% of sampled women in Lokoja and 78.43% of the sampled women in Dekina affirmed that income has an impact on health care utilization by women.

A look into the separate areas of study showed that more women in Lokoja than in Dekina believe that income level can impact on health care utilization by women. On the whole, this result is indicative of the fact that in providing health care services in most part of the world, Nigeria inclusive, out-of-pocket service is the basis upon which healthcare services is utilized and this has enormous implication on women's health bearing in mind the general low socio-economic status of women especially in a less developed country like Nigeria.

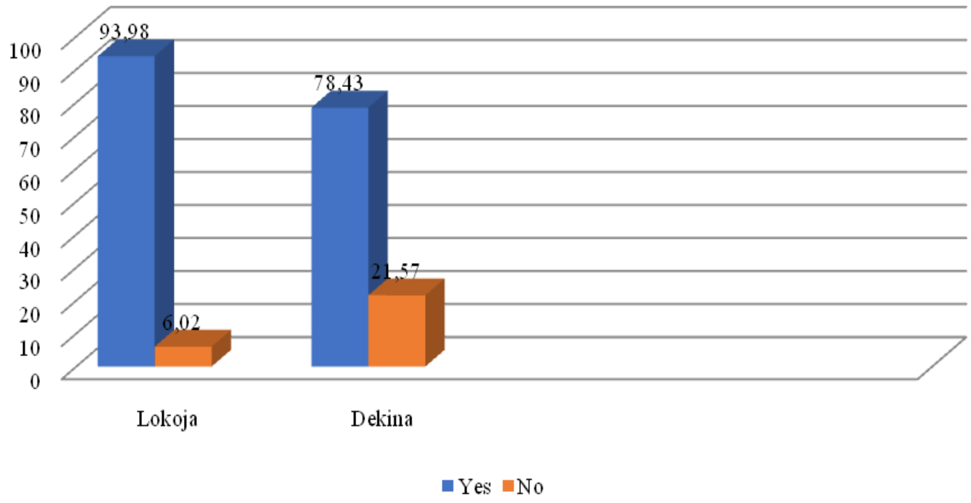

Figure 4. Distribution of Respondents by Belief That Women's Income Can Influence the Way They Use Health Care Services.

Source: Survey (2016)

The above table (5) shows the distribution of respondents as to how income can influence women's use of health care services in the areas of study. More respondents have emphasized on the quality and timing of hospital visits as ways by which the impact of income can be felt in utilizing health care services when the need arises.

This result is indicative of the fact that the quality and timing of consulting health care practitioners during illness episode, will in the view of the respondents measure the effectiveness of the associated link between income and health care utilization.

Table 5

Distribution of Respondents by the Ways in which Income Can Influence Their Use of Health Care Services

	Multiple Items Chosen by Respondents	**Lokoja(%)**	**Dekina(%)**	**Total(%)**
1	Quality of healthcare services, and the time to visit the hospital	44(18.80)	68(25.28)	112(22.3)
2	The time to visit the hospital, quality of healthcare services and 'others'	55(23.50)	68(25.28)	123(24.5)
3	The Place to visit for healthcare service	28(11.97)	100(37.17)	128(25.4)
4	'Others'	87(37.18)	21(7.8)	108(21.5)
5	I can't really say	20(8.55)	12(4.46)	32(6.4)
	Total	234(100)	269(100)	503(100)

Source: Survey (2016)

Additionally, data gathered from the FGD participants suggests that women who earn better income choose where they intend to receive health care. In support of the above position, a FGD participant opined that:

> To get treated, one needs money so I am of the opinion that if women earn more money, or have more education to be qualified to be put in a position where they earn well, it will determine which health facility to go to whenever they have some kind of health challenges. In my own case if I have a bigger salary I would be going to Federal Medical Centre here in Lokoja and not patronizing the patent medicine stores. It is all about money (female, 43 years, Accountant in Lokoja LGA).

On the other hand, the amount of income or money a woman has in her possession may not matter when the kind or severity of disease conditions is considered. This view is strongly shared by a number of women who opined that in severe cases of disease like a metastasized cancer of the breast for instance, a woman is most likely to express fear over the incurable nature of the disease as it is generally believed that preventing it at this level (metastatic stage) is too late and no amount of money can cure it. Put another way, respondents whose awareness' level of incurable conditions is average, women's level of income can go a very long way in employing measures (e.g., medical checkups, etc.) in preventing and lessen the likelihood of occurrence of such incurable diseases. A FGD participant also summarized the perception of the majority thus:

> Depending on the nature and severity of the diseases or ill health, the amount of money women earn monthly or yearly may be inconsequential. For instance, for a condition like cancer, no amount of money or income is sufficient to treat this. The only way to by pass this is through awareness, exposure and early detection. Therefore, money can do very little because of the high cost of treatment (female, 51 years health worker in Dekina LGA).

DISCUSSION

This study attempted to describe women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State, Nigeria. In doing this, data were obtained from the study's respondents, analyzed and interpreted accordingly. First, regarding the level of health care utilization as reported by the women in the study, result revealed that majority of the women in the study sample reported that they have most frequently utilized health care services during incidences of chronic disease like hypertension, diabetes, etc in the past six months. This result is not surprising because chronic diseases that are associated with life-style and other

risks factors have become increasingly prevalent in Nigeria and therefore compels both men and women to seek healthcare. This thus explains why the majority of women in this study have visited the hospital more for incidences of chronic diseases than any other type of diseases. On the other hand, regarding health issues such as illnesses and cold, injury, menstrual related problems like stomach ache, etc., check-ups, depression, family planning, pregnancy related visits (e.g., antenatal visits or complication, etc), medication visits and hospital admission, surgery related visits, and visits for oral health problems, the self-reported health care utilization scores showed that women visit less frequently. This result is consistent with that of Rendendo-Sendino, Guallar-Castillon, Banegas, and Rodriguez-Artalejo (2006) which found out that women visit the hospital more during chronic health conditions than any other health conditions.

The reason for this outcome is perhaps due to the fact that some conditions or illnesses are considered minor with little or no harm to the body of a woman especially when she is not pregnant. As a result, when a woman feels headache or pains associated with her menstrual period for instance, she finds a way of treating it without going to the hospital, although she may visit the hospital when experiencing excruciating pains associated with such conditions. However, for health behaviours such as check-ups, the women in the study may have never visited or visited less frequently because of the financial implication associated with such health behaviour. In the final analysis, the cost associated with, and the severity of any health issues may serve as impediments to the utilization of healthcare services by women in the study areas. Thus, this result implies that women in this area would only attempt to utilize more of healthcare services when they are faced with life threatening situation than at other times.

As to whether there is a perceived effects of women's educational levels on health care utilization, result revealed that most of the respondents through multiple item responses believed that educational levels of women can impact on the following: frequency of visits, decision to go or not to go, time of visits, and quality of treatment. This result is consistent with findings of Coimbra et al. (2007), Owens, (2008), and Pillai et al. (2003) who maintained that the quality and the levels of women's health care utilization is largely dependent on their SES and other socio-cultural factors in which women find themselves; but contrary to the findings of Ochako et al. (2011) who found a seemingly counter-intuitive effect of education on early antenatal utilization. This goes to show the importance of education on healthcare use as it has been observed to be the foundation upon which other SES (e.g., occupation and income) is premised (Michaelowa, 2000) and ultimately the needed impetus that transforms healthcare information to health care utilization (Aue and Roosen, 2010; Geyer, Hemstro, Peter, and Vagero, 2006; Ivancic, Mirceva and Vrecer, 2008; Lahelma, Martikainen, Laaksonen and Aittomaki, 2004; Lynch and Kaplan, 2000; Mackenbach, Meerding and Kunst, 2007). On the other hand, data from the qualitative analysis suggested that

education may have little to do with women's health care utilization as some women (FGD participants) in the study disregard the importance of education in health care utilization but expressed biological, social, and emotional dependency on their husbands for their health care utilization.

Additionally, analyses of data revealed that the type of jobs women engage in may produce significant impact on the following: length and duration of visits, frequency of visits, and quality of treatment. This result corroborates that of Pebley, Goldman, and Rodriguez (1996) and Stekelenburg et al., (2004) that women with formal jobs were more likely to use healthcare services while other studies found no effect of women's working status or occupation on health care utilization (e.g., Elo, 1992; Toan et al., 1996; Mekonnen and Mekonnen, 2003; Duong, Binns, and Lee, 2004; Chowdhury et al., 2007). One explanation for this outcome still lies in the general belief that women who work outside of home are saddled with dual responsibilities of keeping the family together and staying relevant at work which in the long run impact on the way women respond to their own health. This situation may largely affect women's length and duration of hospital visits, frequency of hospital visits, and quality of treatment received at the hospital during illness episode. Also, result from the FGD showed that for women who do demanding jobs and still manage to attend to compulsory home affairs, healthcare utilization may be challenging. This finding is congruent with the study of Novak (2010) who opined that individuals who are engaged in demanding jobs may have difficulties in maximizing the potentials of healthcare facilities and personnel have to provide.

Lastly, result revealed that the amount of income women earn can influence; quality of healthcare services, the time to visit the hospital and the place to visit for healthcare services. The result from the FGDs also indicated that out-of-pocket health care expenses can only be possible when women earn better income. While contrary to the findings of Larson and Correa-de-Araujo (2005), the present study agrees with studies elsewhere (Buor, 2003; Mackenbach and Howden-Chapman, 2003; Månsdotter, 2006; Taffa and Chepngeno, 2005), which established that women with high income are more likely to use health care more than women with low income in under virtually all circumstances. One explanation for this outcome may not be far from the logical notion that earning enough income translates to better health care utilization and subsequently better health status. Whether this is true or not for women, the reality of the low status of women coupled with the rising cost of healthcare may complicate healthcare utilization for women. Be that as it may, the relevance of regular and substantial income for women cannot be overemphasized in their healthcare utilization experience. Also, the severity of a disease o health conditions can mean a lot for a woman beyond her earnings.

While the perceived effects of SES (education, occupation and income) have been examined in different dimensions, the behavioural model of Andersen has helped in explaining how these measures of SES impact on the health attitudes

beliefs and behaviors of women in the study. For instance, variables or factors (under predisposing factors) such as gender (being a woman), marital status, age, education, occupation, etc have been found to impact on the health belief and attitude as well as the manner of health care utilization in the study. Similarly, Andersen's enabling factors (e.g., income and individual's wealth) have been confirmed by the findings of this study to enable women in utilizing health care. Finally, Andersen's need factors (especially the perceived needs of the women in the area of study) have provided newer insights into how these women view their body, health status and approaches to seeking health care services. However, some aspects of this study's findings contradicts Andersen's behavioral model, suggesting that a woman's education, occupation and or income do not necessarily determine health care utilization.

LIMITATIONS AND CONCLUSION

This study has attempted to describe women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State. It is believed that this study is a stepping stone to advancing further research endeavours in the area of women's SES and health care utilization in Nigeria and other places around the world. However, the current study is limited in the following areas, which we hope further research endeavours can help improve upon in future:

1. The validated health care utilization instrument (SPERCHUS) cannot be generalized to ranges of populations except the specific population of the present study. It will therefore be necessary to carry out more validation research on the health care utilization scale (SPERCHUS) or its equivalent, which was adopted in this study in order to understand how women use healthcare services in other areas in this country.
2. Relying on self-report may be misleading in a research of this nature. Reasons being that individuals may experience memory loss, inaccurate references and so forth in reporting their frequency of health care utilization. In order to avoid this type of limitation in future research related to the current subject, More qualitative (such as participant observation of clinical and household experience) studies are encouraged so as to get more insights into the dynamics and factors involved with women's health care utilization as quantitative studies can get little information as to the true nature of SES and other factors that may influence health care utilization by women.
3. In this study, we did not inquire into the perspective of men on the effects of their SES on their wives or women's health care utilization. Although, the women tend to give convincing insights into the subject matter for the

study, getting additional insights from men may have provided further insights into the study. To this end, research could be carried out to compare the nature of health care utilization between men and women as well as how their SES influences their health care utilization or that of the women's.

Based on the results of this study, the following conclusions were reached:

1. Women in the study sample have most frequently utilized health care services during incidences of chronic disease like hypertension, diabetes, etc in the past six months and less frequently visited the hospital for other health issues or needs such as illnesses and cold, injury, menstrual related problems like stomach ache, etc., check-ups, depression, family planning, pregnancy related visits (e.g., antenatal visits or complication, etc), medication visits and hospital admission, surgery related visits, and visits for oral health problems in the past six months. This may be reflective of the reality of the pattern of health care utilization in the parent population, Kogi State.
2. Education, occupation and income impact women's decision, quality of treatment, frequency of visits to the hospital, length and duration of hospital stay, time of visits to the hospital, and the type of health facility to visit. The study therefore recommends that women's socio-economic standing must be improved by workable policies that are aimed at improving their chances in the socio-economic ladder in order for them to fully maximize the opportunities inherent in the utilization of health care services.

REFERENCES

AKANDE, T. M., & OWOYEMI, J. O. (2009). Healthcare-seeking behaviour in Anyigba, North Central Nigeria, *Research Journal of Medical Sciences*, Vol. 3(2), 47–51.

AMERICAN PSYCHOLOGICAL ASSOCIATION, TASK FORCE ON SOCIO-ECONOMIC STATUS. (2007). *Report of the APA Task Force on Socio-economic Status.* Washington, DC: American Psychological Association.

ANDERSEN, R. M., & NEWMAN, J. F. (1973). Societal individual determinants of medical care utilisation in the United States. *Milkbank Memorial Fund Quarterly*, Vol. 51, 95–124.

ANDERSEN, R. M., RICE, T. H., & Kominski, F. (2007). *Changing the U. S Health Care System: Key Issues in Health Policy and Management*. USA: Wiley.

AZUH, D., FAYOMI, O., & AJAYI, L. (2015). Socio-cultural factors of gender roles in women's health care utilisation in Southwest Nigeria, *Open Journal of Social Sciences*, Vol. 3, 105–117. Retrieved from http://dx.doi.org/10.4236/jss.2015.34013

BABBIE, E. (2013). *The Practice of Social Research.* United States: Wadsworth, Cengage Learning.

BHATTACHERJEE, A. (2012). *Social Science Research: Principles, Methods, and Practices*. South Florida: Scholar Commons.

BREDENSEN, J. A. (2013). Women's use of healthcare services and their perspective on healthcare utilisation during pregnancy and childbirth in a small village in Northern India, *American International Journal of Contemporary Research*, Vol. 3(6), 1–9.

BUOR, D. (2003). Analysing the primacy of distance in the utilisation of health services in the Ahafo-Ano South district, Ghana, *International Journal of Health Planning &Management.,* Vol. 18(4), 293–311.

CHAKRABORTY, N., ISLAM, M. A., CHOWDURY, R. I., BARI, W., & AKHTER, H. H., (2003). Determinants of the use of maternal health services in rural Bangladesh, *Health Promotion International*, Vol. 18(4). doi:10.1093/heapro/dag414

COCHRAN, W. G. (1963). *Sampling Techniques*. New York: John Wiley and Sons.

COIMBRA, L. C., FIGUEREDO, F. P., SILVA, A. A. M., BARBIEN, M. A., BETTOIL, H. CALDAS, A. J. M., MOCHEL, E. G., & RIBERO, V. S. (2007). Inadequate utilisation of prenatal care in two Brazilian birth cohorts, *Braz J Med Boil Res,* Vol. 40(9)*,* 1195–1202.

CURRIE, J. (2005). *The Marketization of Depression: The Prescribing SSRI Antidepressant to Women*. Toronto, ON: Women Health Protection.

EZE, B. U., & ADHURE, H. (2014).Hindrances to effective usage of family planning methods among women in Adankolo Lokoja urban area of Kogi State, *International Journal of Current Research and Academic Review*, Vol. 2(10), 182–190.

GEDA, A., & SHIMELES, A. (2009, November).*Demand for health in Ethiopia: Exploratory analysis from welfare monitoring surveys*. Paper presented at the African Economic Conference, Addis Ababa.

HALLE-EKANE, G. E., OBINCHEMTI, T. E., NZANG, J. L. N., MOKUBE, M. N., NJIE, M. M., & NJAMEN, T. N. (2014). Assessment of the content and utilization of antenatal care services in a rural community in Cameroon: A cross sectional study, *Open Journal of Obstetrics and Gynecology*, Vol. 4, 846–856.

HARALAMBOS, M., & HOLBORN, M. (2013).*Sociology: Themes and Perspectives*. London: Collins.

HOGAN, V. H., AMAMOO, M. A., ANDERSEN, A. D., WEBB, D., MATHEWS, L., ROWLEY, D., & CULHANE, J. F. (2012). Barriers to women participation in inter-conceptional care: A cross-sectional analysis. *BMC Public Health*, Vol. 12(93), 2–10.

HULKA, B. S., & WHEAT, J. R. (1985). Patterns of utilisation.The patient perspective, *Medical Care*, Vol. 23(5), 438–460.

LORIG, K., STEWART, A., RITTER, P., GONZALEZ, V., LAURENT, D., & LYNCH, J. (1996). *Outcome Measures for Health Education and other Health Care Interventions.* Thousand Oaks CA: Sage Publications.

MACKENBACH, J. P., & HOWDEN-CHAPMAN, P. (2003). New perspectives on socioeconomic inequalities in health, *Perspectives in Biology and Medicine*, Vol. 46(3), 428–444.

MAJAJ, L., NASSAR, M., & De ALLEGRI, M. (2011). Health seeking behaviour and acknowledgement of rural Palestinian women. *The Lancet Journals.* Retrieved from http://www.thelancet.com/pb/assets/raw/Lancets/Abstracts/palestine/palestine2011-6.pdf

MAMURNUR, R., & ANTAI, D. (2014). Socioeconomic position as a determinant of maternal healthcare utilization: a population-based study in Namibia, *J Res Health Sci*, Vol. 14(3), 187–192.

MANSDOTTER, A. (2006). *Health, Economics, and Feminism – on judging fairness and reform* (New Series No 1013).Sweden: Swedish National Institute of Public Health Stockholm.

MWABU, G. (2009). Health economics for low income countries. In H. Chenery & T. N. Srinivansa (Eds.), *Handbook of Development Economics* (ch 53). New York, NY: Guilford Press.

NATIONAL POPULATION COMMISSION. (2010). *2006 Population and Housing Census Priority Table Volume III Population Distribution By Sex, State, LGA & Senatorial District.* Abuja: Federal Republic of Nigeria. Retrieved from http://www.population.gov.ng/

OCHAKO, R., FOTSO, J.-C., IKAMARI, L., & KHASAKHALA, A. (2011). Utilisation of maternal health services among young women in Kenya: Insights from the Kenya Demographic and Health Survey, 2003, *BMC Pregnancy &Childbirth, 11*.OWENS, G. M. (2008). Gender differences in health care expenditure, resources utilisation and quality care, *J. Manag Care Pharm*, Vol. 14(3)*,* 2–6.

PILLAI, R. K., WILLIAMS, S. V., GLICK, H. A., POLSKY, D., BERLIN, J. A., & LOWE, R. A. (2003). Factors affecting decisions to seek treatment for sick children in Kerala, India, *Social Science & Medicine*, Vol. 57(5), 783–790.

REBHAN, D. P. (2008). *Health Care Utilisation: Understanding and Applying Theories and Models of Health Care Seeking Behaviour*. Cleveland: Case Western University.

REDONDO-SENDINO, R. S., GUALLAR-CASTILLON, P., BANEGAS, J. R., & RODRIGUEZ-ARTAJELO, F. (2006).Gender differences in the utilisation of health care services among the older adults population of Spain, *BMC Public Health,* Vol. 6(155)*,* 12-21. doi: 10.1186/1417–2458–6–155.

RYAN, G. W., & BERNARD, R. H. (2003).Techniques to Identify Themes. *Field Methods15(1)*, 85–109.

SHAH, R., & BELANGER, D. (2011). Socio-economic correlates of utilisation of maternal health services of the tribal women in India, *Canadian Studies in Population,* Vol. 38(1/2), 83–98.

SHANK, G. D. (2002).*Qualitative Research: A Personal Skills Approach.* Upper Saddle River, New Jersey: Pearson Education.

SMITH, J. A., & OSBORN, M. (2007). Interpretative Phenomenological Analysis. *Qualitative Psychology*, 53–80.

SWEDO, E. A. (2012). *Stemming the tide: A study of technical and perceived quality of care and their association with maternal health determinants* (Unpublished master's thesis). Rollins School of Public Health of Emory University, Atlanta, G. A.

SNAKES, SNAKEBITES AND BRITISH MEDICAL-ZOOLOGICAL ENGAGEMENT IN EARLY COLONIAL INDIA: HEALTH, MEDICINE AND IDEOLOGY*

RAHUL BHAUMIK[1]

ABSTRACT

This paper tries to trace the interesting history of Western medical-zoological engagement with venomous Indian snakes within the context of making and consolidation of British health policy in colonial India during the late eighteenth to the mid nineteenth centuries. It shows that while the British colonisers began to exploit flora and fauna of the newly subjugated land for their material benefit, they confronted wild Indian creatures like venomous snakes and anxiously noticed the huge mortality from snake poisoning in India. This threw a direct challenge to the healthy livelihood of the colonisers because of their insufficient knowledge about such a variety of snakes and their envenoming powers. The paper shows how Indian snakes formed a significant part of the British medical-zoological imagination of Oriental/tropical wilderness; a cruel, chaotic and disease-laden condition posing a threat to the life and health of the Europeans and also how the difficulties faced in snake-ridden India were engaged with the idea that India was essentially different from Europe: environmentally and medically. This paper concludes that Western medical engagement with venomous snakes and the consequential health measures which flourished under the British agency provided the tools to order and control the snake-ridden landscape of India and paved the way for the assertion of an intellectual superiority over the colonised people. In this regard, Western medicine and health policy, not only as practice but also as ideology, served to justify the colonial rule and became a true instrument of the British Indian Empire.

Keywords: *Snake Poisoning, Wild Orient/Tropics, British Health Policy, Colonial/Tropical Medicine, British India.*

---

* Based on a presentation at a Wellcome Trust funded seminar on 'Environment and Health: Colonial and Postcolonial Perspectives in India' organised by the Department of History and the Centre for Social Sciences and Humanities, University of Calcutta in September 2016. I would like to thank Prof. Srilata Chatterjee and Prof. Nupur Dasgupta for their useful and helpful comments on this talk and Dr. Sudeshna Banerjee and Prof. Arun Bandopadhyay for the time and trouble they took to discuss the contents with me. I am also grateful to Dr. Ananda Mukhopadhyay for his help and finally to the three anonymous reviewers of this journal for their valued suggestions that substantially improved the article.

[1] Department of History, Jadavpur University, 188 Raja S. C. Mallick Road, Kolkata, West Bengal, India. Email: rahul_joy1981@yahoo.com

BY-ND
Creative Commons License
Attribution–NoDerives CC-BY-ND 4.0

INTRODUCTION

In the past four decades there have been a lot of excellent researches and writings on the history of biomedicine in European colonial territories during the eighteenth and nineteenth centuries. Particularly, the history of Western medicine in British India is increasingly attracting the attention of scholars from a range of disciplinary locations, leading to the emergence of varied themes and perspectives (Arnold 1993; Bala 1991; Harrison 1994; Kumar 1998; Kumar 2001, 123–275; Kumar and Basu 2013; Palit and Dutta 2005; Pati and Harrison 2006, 2009; Sharma 2012). Much of these scholarly exercises have meticulously studied the neglected features of the social history of health and medicine in British India emphasising the symbiotic relationship between Western medical science and colonial exploitation and dominance. They have shown that, as the 'tools' of imperialism Western medicine was mainly used to protect the European traders, soldiers and officers from the hostile and disease-laden colonised landscapes and thus largely helped in the extension and consolidation of colonial rule in India.[2] Researches in the socio-cultural history of tropical disease and medicine have also focused on the ways in which tropical India, in the light of climatic theories of maladies, was imagined as a land of dirt, disease and sudden death, though, not perhaps quite as a 'white man's grave' like the west coast of Africa, but as fundamentally unhealthy and deadly for 'white' bodies (Arnold 1996b, 2005; Chakrabarti 2012; Curtin 1989; Harrison 1999).

A number of works, with reasonable clarity, have accepted the idea that colonial/tropical medicine was, actually, an integral part of the colonial governance. As a hallmark of the European racial pride and cultural superiority, modern biomedicine underpinned imperialism in India not only by reducing the mortality and morbidity of the colonisers and their 'native' collaborators, but also by socially and culturally controlling the bodies and minds of the colonised people, in order to mould their ideas, belief and desires to the best advantage of the Europeans. Needless to say, these recent studies have done much to construct a usable history of health and medicine in modern India. But, they have hardly engaged themselves in the history of snakebite morbidity and mortality or the extensive medical-zoological research on snake venom, that was undertaken during the years of British rule in India–a lacuna that this paper someway attempts to fill-up.[3]

Drawing on the burgeoning field of scholarship, the present paper is an attempt to understand the medical history of British India through the prism of snake and its venom. More precisely, this work considers the particular case of

---

[2] For the pioneering work on the role of Western medicine as 'tools of empire', see Headrick 1981, 58–79.

[3] In recent years, however, a growing interest in the history of colonial medical engagement with Indian snakes and their venoms is being noticed. See, for example, Bhaumik, 2012; Chakrabarti 2012, 86–178.

British engagement with the 'terror' of venomous Indian snakes and the colonial medical management of the 'evil' of snakebite deaths in India during the late eighteenth to the mid nineteenth centuries.[4] Focusing on this particular health issue, to which medical historians have paid little attention, this paper shows that medical-zoological engagement with snake varieties and snake venoms did indeed aid the British colonisers' effort to sustain and strengthen their domination over India by reducing the risk of mortality involved in the colonial project and most significantly, by providing the image of the social and cultural malignancy of the indigenous people of a snake-infested country they gradually conquered and ruled. Indeed, this paper seeks to demonstrate the way in which the Europeans' study of snake and venom in India and their medical search for the remedy of envenomation enormously helped the colonisers to create a dichotomy between Europe and its 'Others',[5] in order to assert European racial and cultural superiority over the indigenous Others and in the process, extend and maintain European hegemony over the 'wild' and 'dangerous' Oriental/tropical landscape inhabited by the 'disorderly' and 'inferior' Others.

Against this backdrop, this paper is specifically interested to provide a critic of British construction of the medico-geographic categories like 'tropics', 'tropical disease' and 'tropical wilderness'. The relationship between 'tropical medicine' and colonial politics of difference is particularly germane to our study. After all, the gamut of medical-zoological study of the snakes in India fashioned a significant part of the construction of an essential difference for 'warm' or 'hot' climates (as distinct from the temperateness of Europe); tropical medicine was about addressing this essential difference. It is true that tropical medicine, as a speciality within colonial medicine and as a prominent colonising force, did not emerge before the 1890s (see Worboys 1976, 1988 and 1993). But as persuasively argued by David Arnold (1996, 5) and Mark Harrison (1992, 299-300), we are probably justified in using the notion of tropical medicine in relation to the colonial medical engagement with snake venom pertaining to earlier period of the late eighteenth to the early nineteenth centuries.

However, this paper shows that, as in the case of all other specialisations under tropical medicine, the medical study of snake envenomation in India had two layers of hegemonic signification. At one level, it was an indication of the self-conscious claim of the colonial medical establishment, as projected in their healthcare strategy, that it could somehow manage the problem of snakebite-induced mortality. At another level, it served as an ideological weapon to demonstrate the superiority of the West over the tropics. It enhanced the colonisers' status as a modern race that only could produce 'scientific' knowledge about the aetiology of the disease of snake envenomation specific to the tropical

[4] For the British idea that venomous Indian snakes are 'terror' or 'evil' because of the horror they spread and the lethal harm they caused see, Fayrer 1878.

[5] On the European construction of the 'Other', see Said 2001.

climate. This paper shows that the implicit deployment of the notion of the tropics in relation to snake poisoning and healthy living in colonial India also privileged the concerned medical practitioners to take a 'civilising' role and enhanced their status as knowledgeable persons among a supposedly unenlightened indigenous population.

ENCOUNTER WITH VENOMOUS INDIAN SNAKES

By the end of the eighteenth century, the English East India Company (hereafter EEIC) became an ad hoc colonial power on the Indian subcontinent. From the 1750's successive British military victories over the 'native' rulers and other European competitors enabled the Company to incorporate more territories under its influence. While the Britons started to explore their newly conquered terrain, they were amazed to see the numerous varieties of Indian flora and fauna. The European merchant-rulers were excited about the opportunity that the vast natural kingdom of India offered in natural history studies. They became keen to identify commodities that could be profitably exported to their homeland and in the process started cultivating commercial plants and found botanical substitutes for drugs and simples. While the British successfully began to exploit plants and herbs of India for their material benefit, 'wild' Indian creatures like venomous snakes virtually became an anathema to the emerging British ascendency in the subcontinent. What they anxiously noticed was the huge mortality from snake envenomation in India.[6] The presence of numerous species of snakes in India, many of which are 'dangerously' venomous, threw direct challenge to the everyday livelihood of the colonisers. The hopeless situation became all the more critical because of the colonisers' insufficient knowledge about such a variety of snakes and their envenoming powers as their exposure to lethal snakebite was rare in their homeland (in this case in Britain).[7] Therefore, the Western medical-zoological knowledge that the colonisers borrowed from their homeland could not effectively help them to manage venomous snakes and snakebite mortality in India–a very vital requirement for the imperial expansion and establishment in the subcontinent.

In this scenario, the initial reaction of the colonisers towards snake envenomation seems to be ophidiophobic. For example, William Mackenzie, a physician from Madras Presidency, wrote in an article published in the Asiatic Society's periodical in 1820:

---

[6] For example, Joseph Fayrer of the Indian Medical Service in a report to the *Nature* quantified snakebite deaths across seven administrative regions representing about half of British India and found that 11,416 people had died of snake poisoning in 1869. See Fayrer 1882, 206.

[7] Recorded incidental deaths from the bite of Adder (*Vipera berus*), the only naturally occurring venomous snake in Britain, were very few in numbers in comparison with that in India. Statistics partially shows that only fourteen deaths occurred in Britain during the hundred years from 1876 to 1975. See, Reid 1976, 154. Whereas, every year over 15,000 people reportedly die due to snake poisoning in India. See, Swaroop and Grab 1954, 57–58; Warrell 2005, 10.

> Soon after the opening of the bar in the month of October 1815, reports were circulated at *Madras*, that a great shoal of sea snakes had entered the river, and that many natives in crossing it had been bitten and had died. These reports caused so serious an alarm among the natives, that they attracted the attention of the superintendent of the police, who on enquiry ascertained that three individuals after crossing the river *had died*, and their death had been occasioned (as was universally believed) by these snakes. In consequence of this information, a reward was offered for each sea snake caught on the condition of being carried to the police office (Mackenzie 1820, 329).

What strikes the reader most is the panicky reaction of the colonisers to the snakebite deaths. Though the above author noted only three deaths induced by snakebites during the concerned period, the local Superintendent of Police became so anxious that he immediately declared a reward for each sea snake brought to the police station. Such a prompt action indicates that, far from being taken it lightly, the incidence of three snakebite deaths was indeed taken as a challenge to the emerging edifice of colonial rule. Similarly, the author's reaction to the presence of 'great shoal of sea snakes' causing 'serious alarm' reflects an obsession with the fear of snakes and their venomous bites shared by the officials of the EEIC.

True that the British sought to make the 'European Town' or the 'White Town' as clean as possible relative to the 'Black Town,' the habitat of the Indians[8] and thus minimise the possibility of vipers besieging the 'white' home. Yet, on several occasions, the Europeans were about to receive their death-wounds from mischievous snakebites. For example, Reginald Heber who reached India in 1823 and served as the Bishop of Calcutta, in his famous travel diary, recounted on 18 September 1824 a thrilling story he had heard of an English woman at Patna who once spent a whole night with a venomous Indian cobra under her pillow. In the morning when the lady suddenly snatched her pillow away she spotted the most dreaded reptile in India coiled up within two inches of her neck. After describing the episode, Heber sarcastically remarks: 'The snake was without malice, his hood was uninflated, and he was merely enjoying the warmth of his nest; but, alas! for her, if she had during the night pressed him a little too roughly!' (Heber 1829, 280). There are several similar stories like the tale of Lieutenant Colonel Edward James Corbett, more familiar as Jim Corbett, who was once trapped in a small dark bathroom of his Mokameh Ghat residence with 'one of the most deadly snakes in India', a 'wicked-looking' big cobra, and successfully rescued himself from the 'horror' situation (Corbett 1968, 185-187). However, European residents surely could not always get such a narrow escape from the bites of venomous snakes and sometimes became victims to snakebites. As for example, in the year 1809, Civil

[8] Actually in colonial India European town planning and building style took on a racial form, with sincere attempts to protect Europeans–civilians and military–from the numerous 'native diseases'. See, Jeffery 1988, 96-97; Metcalf and Metcalf 2008, 108–111; Metcalf 1998, 177–179.

Surgeon of Chittagong, John Macrae was bitten by a snake on his right leg at night, while he was walking on the southern veranda of his house. In depicting this evil fortuity, Macrae wrote in the *Asiatick Researches*:

> On the night of the 12th of May, on stepping into the southern verandah of my house, I observed a small snake, of a dark colour, running along the terrace; and which, after several unsuccessful attempts, I at length hit and killed, with a small cane I had in my hand. Immediately thereafter, as I walked, I felt a slight uneasiness below the inner ankle of my right leg, as if I had taken off a bit of the skin, and this, I imagined, I had done, with the heel of the other foot, in my eagerness to kill the snake; and therefore, after gently rubbing the part with my hand, I thought no more of it; but in a few minutes, returned into the house, and began to undress to go to bed...The uneasiness at my ankle still continued as before, without appearing to increase, and I recollected, that while endeavouring to kill the snake, it had once made a dart towards me, and got between my feet, but as I did not perceive it to touch me, I was unwilling to ascribe to so alarming a cause, the unusual sensations I felt; yet I could not otherwise account for them (Macrae 1810, 310–311).

Thus, the colonisers in India were not feeling safe in their own houses, despite their 'better' health and sanitary strategies and policies. Fortunately in the first two cases the British residents were not bitten by the dreadful cobras and in the last case the snake was too 'small' to be poisonous enough to kill an adult, but usually death was a common occurrence and the colonisers, as their writings show, became very much anxious about it.

INVENTING TROPICALITY AND CREATING DIFFERENCE

As evident, in this scenario, a sense of fear and anxiety for the possibility of being confronted with venomous snakes and bitten by them somehow came to persist among the colonisers, which was frequently projected in a range of colonial literature concerning Oriental jungle and lifestyle. For example, the Europeans' enduring obsession with the idea of venomous Indian snake in tropical jungle, stirred up Rudyard Kiplingin 1894 to inimitably portrait this reptile as an attractive but mysterious and deadly creature:

> From the thick grass at the foot of the bush there came a low hiss–a horrid cold sound...Then inch by inch out of the grass rose up the head and spread hood of Nag, the big black cobra, and he was five feet long from tongue to tail. When he had lifted one-third of himself clear of the ground, he stayed balancing to and fro exactly as a dandelion-tuft balances in the wind, and he looked...with the wicked snake's eyes that never change their expression, whatever the snake may be thinking of (Kipling 2015, 137–138).

Thus, with a strange manner of livelihood and behaviour, quick yet mysterious sinuous motion, the cold fixity of gaze, unpredictable appearance from the void without any noise, the snake perfectly appeared in British imagination as a sign of wild and perilous Indian landscape. India appeared as an alien snake-infested territory, where the threat of snakebite made the colonisers feel as being utterly vulnerable to physical injury and consequential death as they were required to travel throughout this country. The anonymous author of the book titled *India: Illustrated*, pointed out that:

> One of the greatest drawbacks to life in India is the great number of poisonous snakes that are found. They creep into the houses and even into the beds; they drop down from the thatched roofs; they lie coiled up in the roadways, and are everywhere. It seems almost incredible, but nearly forty thousand people die every year from their bites. From such a scourge there seems no way of escape (Anon. 1876, 60–64).

Thus, Indian snakes formed a significant part of the British medical-zoological imagination of Oriental/tropical wilderness–a cruel, chaotic and disease-laden condition posing a threat to the life and health of the Europeans.[9] Noticeably, British imagination of the Orient and their romantic and commercial interest in tropical nature and fauna also induced them to a similar engagement with Indian mongrel dogs or as referred as 'pariah' dogs,[10] carriers of rabies and another symbol of tropical wilderness to them and subject of colonial medical-zoological experimentations (Chakrabarti 2012, 91–94). These dogs were abundant in number and usually maintained by the Indian villagers, but to the colonisers, pariah dogs in the streets were again a grim reminder of the sylvan and savage tropics, exposing them to the danger of hydrophobia and sure deaths. Prejudiced by this growing anxiety for epidemic of rabies, the European soldiers and officers tried their best to censure the Indians for their 'reluctance and inability to control the mongrels in their localities' (Chakrabarti 2012, 93). Actually, the vast alien and untamed tract of wilderness in India obsessed the colonisers so much so that they imagined themselves as being hounded by several recalcitrant deadly creatures and their attitudes towards these wild animals somehow resembled their attitude towards 'native' Indians. It was in this context that, both Indian wildlife and social life became subjected to intense scrutiny and containment of these became almost a mission for the growing European interest in the colony.

Against this backdrop, the general attitude of the British colonial officials and medical practitioners towards venomous Indian snakes was to view them as 'evil'

---

[9] For the colonising discourse that constructed the tropical world as the West's environmental Other, see, Arnold 1996b, 2005; Harrison 1999; Metcalf 1998, 171-185.

[10] The term 'pariah' originally referred to a low-caste community of South India. It was used by the colonisers to condemn the mongrel street dogs of India as outcastes. Chakrabarti 2012, 92.

or source of 'disorder' and 'it seems obvious that more effectual measures are needed to mitigate, if not prevent, this evil' (Fayrer 1878, 2). So a strong sense of animosity towards Indian snakes gradually grew and substantially persisted among the colonisers. Interestingly, this attitude was quite unparalleled in the traditional Indian perception about snakes. Indigenous mode of living exposed Indians greatly to deadly envenomation. The majority among them preferred to travel in bare feet, sit on the floor and sleep on the ground, and readily became victims to snakebites, often incurable and destructive. Therefore, the loss of life from snake poisoning was frequent and huge in this country. But what is important to notice is that, although death from snakebite was treated as a tragic incident in indigenous families, this had never been translated into a phobia about snake. Rather, this frequent exposure to the possibility of snake envenomation generated various indigenous creative literatures like *Manasāmaṅgal Kāvya* in pre-colonial Bengal[11] and varied medical writings on snakebite, like the two key texts of Ayurvedic medicine, the*Caraka Saṁhitā* and the *Suśruta Saṁhitā*,[12] integrally informing veneration for snakes rather than any phobia. There are plenty of evidences which show that Indians had a normal relation with venomous snakes and by tradition they were snake-friendly. 'A native gentleman', Sir Madava Row, in one of his lectures clearly indicated how the common Indian subjects usually treated snakes with fellow-filling attitudes. He remarked: 'Though people die from their venomous bites, serpents are worshipped as living deities by many of my fellow-countrymen. Respectable citizens deem it a duty to set apart a cool patch in their gardens for the comfortable residence of snakes' (quoted in Pool 1894, 143). Similarly, in Bengali cultural belief and practice, a domestic sort of snake, called *vāstu sāp*, used to attract universal respect as they were believed to be the guardians of the dwelling houses. This particular species did not suffer any injury from anybody's hands, even though they used to live within very easy reach of all and if accidentally killed by someone, was burned like a human being with all funeral rites and rituals (Bhattacharya 2006, 61–62). Thus, snakes, despite their power of deadly envenomation being known to the Indians, were never socially

---

[11] The famous Bengali epics in praise *Manasāmaṅgal Kāvya* glorifies the snake-goddess Manasā's victory over those who refused to worship her. See Bhattacharya 1961; Bhattacharyya 1962; Biswas 2009; Sen 1953 and 1968. In accordance with the storyline, three major streams of the *Manasāmaṅgal* are identified by scholars, such as: the West Bengal Style, the North Bengal and Assam Style, and the East Bengal (now Bangladesh) Style. Local version of the similar tale is also available in Bihar, Orissa and South India. For a detail history, see Bhattacharyya 1970, 236–415; Dimock 1962; Dimock and Ramanujan 1964; Maity 1966; Smith 1980.

[12] The *Saṁhitās* provide an almost complete list of ophidians of different groups known till then as well as contain some details about zoological classification and identification of snakes, their anatomy and dentition, characteristic features of male and female species, types of bites and their symptoms and remedies. A close reading of these texts **clearly suggests** that indigenous practitioners meticulously studied snakes and their venoms and showed remarkable sagacity and prudence to maintain a good relationship with the snakes around them. See Bhishagratna 2012, 27–73; Mehta et al 1949, 2140–2203.

treated as exotic creatures. Moreover, these reptiles, particularly hooded cobra, *were* extremely popular reptiles of adoration all over India and being worshipped as source of happiness, wealth and fame.[13]The Indians, over a period of time, tried to ward off the peril of snakebites and were eager to counteract their venom medically (see Slouber 2017, 1–132), but above evidences also indicate that any systematic and collective animosity towards snakes was not a common feature at all in traditional Indian lifestyle and customs.

In contrast, the British colonisers' attitude towards Indian snakes was essentially different in its nature and objectives, possibly because the scale and intensity of their intervention into Indian wild landscape were far more extensive and exploitative than those of their predecessors. Interestingly, the British were not the first group of Europeans to have a tryst with this Oriental/tropical wilderness. Indeed, during the sixteenth-seventeenth centuries, the Portuguese and the French were the first Europeans to have developed direct contact with snake-ridden India. Portuguese physician and naturalist Garcia da Orta (1913, 362–364) and French Huguenot Jean Baptiste Tavernier (1889, 152) took great interest on Indian snakes and indigenous medical methods of curing snakebite victims and were not known to have expressed any animosity towards these reptiles. These European sojourners also must have been afraid of being bitten by poisonous snakes during their travel in this country and therefore keen to collect information about indigenous medical treatment of snake poisoning. But their attitudes towards these reptiles did not greatly differ from that of the Indians already stated above. Quite the opposite, the British animosity towards Indian snakes came across particularly pronounced because they were the ones, who meticulously tried to transform non-productive space into a productive landscape in India, a tropical jungle into an empire's garden (see Drayton 2005; Sharma 2012). This brought the colonial regime in direct conflict with the wild animals as well as forest dwellers and *ādivāsīs* (see Chaudhuri and Bandopadhyay 2004; Pati 2011; Rangarajan and Sivaramakrishnan 2012). It was the British colonisers, who came to believe that the unfamiliar and deadly snake-ridden landscape should be tamed and controlled in order to ensure 'better' protection to the health and life of the European soldiers, officers and civilians, who were engaged to bring the barren land and forest under plough for more revenue to the colonial coffer. Undoubtedly, in this situation, the colonial medical-zoological enterprise of mapping of Indian snakes became the veritable of the inner project of scientific Orientalism, a project which was essentially aimed at exercising effective command over Indian wild landscapes. As usual, a strong Orientalist tendency to depict Indian climates and landscape as 'the Other' was found latent in this project which was both exploitative and hegemonic as it

[13] Clearly, there is no place in this paper for extensive discussion on pre-colonial Indian religious and cultural beliefs and values associated with snakes. Even, the literature on snake worship in India is too large to permit comprehensive citation. Selective examples include Deoras 1978, 1-28; Oldham 1905; Rivett-Carnac 1879; Sinha 1979; Vogel 1926.

ultimately enabled the colonisers to assert European superiority over Oriental people and wild creatures.

It is in this context, the difficulties faced in snake-ridden India were engaged with the idea that India was essentially different from Europe: environmentally and medically. In order to interpret and manage Indian snakes and the consequence of their bites, the European medical practitioners constructed their own 'imaginative geography' (Said 2001, 49–73) and accordingly conceptualised snake envenomation as a disease of warm or hot climate. To claim an integral relation between warm climate and the degree of destructibility of this disease, colonial practitioners proclaimed that if the victim was situated in the tropics, the cure would be difficult, because 'the venom of snakes is more malignant during hot dry weather' (Williams 1790, 256). They argued that rapid progress of several symptoms of this 'disorder' peculiarly occurred in tropical environment. Elaborating further on the essential difference of the tropics they portrayed the Indian snakes as: 'much more numerous, and much more dangerous than in *Europe*' (Boag 1799, 103). For example, eminent Scottish physician Patrick Russell, who came to India in 1781 and as a 'naturalist and botanist' of the EEIC initiated the study of the 'natural history of snakes' (Bhaumik 2012), registered that the consequence of snakebite is very different in India from what it is in Europe. In his 1796 seminal book, entitled *An Account of Indian Serpents*, *Collected on the Coast of Coromandel*, he wrote:

> It has been called in question, whether in Europe; the bite of the viper ever proved fatal to man...The case is widely different in respect to the poisons of the Cobra de Capello, and some other Indian serpents. That man is subjected to their deleterious power, is a fact confirmed every year by too many fatal accidents; and the experiments…put it beyond all doubt, that the stronger animals, who resist the poison of the viper, rapidly give up life, to the single bite of a Cobra de Capello (Russell 1796, 77).

This portrayal of difference between Indian and European worlds of snakes usually tied itself up very well with the Orientalist stereotype of projecting India as a dangerous landscape teeming with strange, unfamiliar animals. And as this 'constructed' wild nature continuously threatened European healthy living as well as their commercial investment, immediate taming of this wild landscape was felt essential for the day-to-day enterprise of expansion and consolidation of British dominions in India.

MEDICAL MANAGEMENT OF SNAKES AND THEIR VICTIMS

It became a crucial task for the colonisers to invent medical solution to this 'alarming' disease of snake poisoning if the British possession in India had to be made permanent. A systematic study of snakes of the terrain thus became a vital

necessity and the first tentative step towards this systematic medical management of snake venom in India, as stated earlier, was taken by an amateur Scottish physician Patrick Russell. He examined various Indian snakes, studied nature of their bites, character of venoms and differentiated between venomous and harmless species by their different dentitions (Bhaumik 2012). Several colonial scientific and medical institutes like, the Asiatic Society (1784), the Oriental Museum (1814), major ancillaries to the early colonial establishment, were quick to step in. As a pioneer agency, the Asiatic Society systematically recognised and scientifically constituted medical-zoological knowledge for understanding and regulating the problem of snake poisoning. The Society's periodical *Asiatick Researches* and its successor *The Journal of the Asiatic Society of Bengal* provided a forum for the communication of the results of medical-zoological observations, explorations and researches (Bhaumik 2011). Later the Presidency College (1817), the Calcutta Medical College (1835) and the Zoological Garden of Calcutta (1876) came forward to play crucial roles in the development of laboratory-based pharmacological research on snake venoms and their action on living animals. Thus, the colonisers began an assiduous medical-zoological study of the snakes and their venoms to identify the extent of danger from them and to find a way to counter it. Venomous Indian snakes became objects of intensive scientific study and laboratory experimentation–an endeavour that had never been seen in India before.

However, the colonial scientific and medical institutions created a space where high quality medical engagement with Indian snakes and their venom had gainfully converged. The publication on venomous Indian snakes–comprising of various topics such as possible medical treatment of snake poisoning, snake taxonomy and nomenclature, toxicology, indigenous drug production etc.–in the periodicals and proceedings of these societies were shortly but surely informed by the medical exigencies of the empire. For example, the proceedings of the Medical and Physical Society of Calcutta, dated 6 February 1830, noted:

> The Secretary submitted to the meeting an account of the bite of a snake, successfully treated, communicated by Brigadier Wilson, commanding at Naserabad...There are several points of scientific interest, upon which we understand the Committee of the Society are anxious to obtain information from resident member...Well authenticated details concerning the bites of venomous serpents form also a desideratum in our Eastern literature. A particular description of the reptile called *Biscopra*, and believed by the native to be deadly poisonous, would be also desirable–as well as a description, and well authenticated particulars of the *Cobra Manilla*, &c (Medical and Physical Society 1830, 135).

The proceedings thus described the context in which the European phobia about venomous Indian snakes was translated into an India centric purpose of ophiological knowledge among the more scientifically oriented Europeans in India. Medical-zoological study of snakes thus became the only possible way to mitigate

the disease of snake poisoning and thus heal the prevalent ophidiophobia of Europeans. Indeed, European surgeon-naturalists found advantage in the idea that the gathering of medical-zoological knowledge about Indian snakes and their venoms could induce the best management of snake-ridden Indian condition, as it would assist colonisation by reducing the risk of the lives of Europeans and their 'native' assistants from possible snake poisoning (see Russell 1796, v–ix).

What is important to notice is that, from the outset, medical-zoological study of Indian snakes essentially became a project of the Company Raj aimed at exercising command over Indian 'wild' landscape and 'native' people. European medical practitioners rendered invaluable services to find suitable remedy of snake poisoning alright, particularly through their researches and publications, but there is no reason to imagine their roles as power-neutral. European physician-naturalists, who participated in the scientific and medical institutions' scholarly pursuits of knowledge about snakes and their venoms, did never fritter any single opportunity to condemn Indian disease-laden condition and assert Western superiority over India. As said before, the EEIC's medical officers believed that Indian warm climate was responsible for various fatal and incapacitating maladies and as European contact with this disease-laden landscape gradually increased through more and more imperial conquest and domination, the colonisers became more susceptible to tropical diseases like snake poisoning, etc. Interestingly, from the end of the eighteenth century, an overbearing scientific confidence was noticed in colonial medical discourses that any disease endemic to the tropics could be cured only through the superior knowledge and skill of Western medicine and health programme and the 'torrid zone' thus could be brought under effective control (Chakrabarti 2012, 3–9). With this 'curative confidence' medical men stationed in various parts of British India, explored various possibilities of understanding snake envenomation, a disease of warm climates, in terms of a new medical specialisation. The idea of tropics and the emergent discipline, tropical medicine, provided them the opportunity to construct a fundamental difference between Europe and India, intending that the temperate European landscapes, climate and constitutions were superior to those of tropical India. 'In this view European medical intervention represented progress towards a more "civilised" social and environmental order' (Arnold 1989, 3).

The hegemonic project of bringing snake-infested tropical landscape and its denizens under complete control of the British imperial power was enormously facilitated by the Western exercise of denigrating all the age-old 'native' snakebite-cures as irrational and superstitious. For example, a common indigenous *materia medica* for snakebite, widely used and well known in pre-colonial India as 'bezoar' or 'snake stone', appeared to colonial experts as a mere collection of unscientific practices based on inaccurate knowledge. However, before the last quarter of the eighteenth century, there was hardly any western tradition of questioning the medicinal value of snake stone. Rather, according to French traveller Tavernier, it

was extremely effective when used as an antidote to snake venom (Tavernier 1889, 152). But after the institutionalisation of ophiological knowledge in India, the entire scenario changed rapidly. J. Davy, a reputed physician and interlocutor associated with the Asiatic Society, after examining a few snake stones, claimed that the phenomenon was a hoax and its reputations among the natives were based on popular imagination (Davy 1820, 321). In the same vein, another famous snakebite medicine 'Tanjore pill' was also encountered and discredited by scientific experimentation of the colonial practitioner (Boag 1799, 112–113). Thus the initiation of colonial studies of Indian snakes and their venoms marked a period in which the colonisers in general were not interested in acknowledging the traditional healthcare system of the Other. It is important to mention here that, most of the 'native' people, who lived in remote villages where the cases of snakebites were most frequent, were hardly served by the Western practitioners, engaged mainly at army hospitals and dispensaries in the town areas. Therefore, 'natives' were often not in a position to enjoy Western medicine and healthcare system and perhaps, not really regretted for that, relied extensively onthe expertise and knowledge of indigenous snakebite-curers like Ojhā, Guṇin, Kavirāj, Vaidya and Hākimin the genuine cases of envenomation. These indigenous medicine-men, who were experts in healing snakebite in their own ways and over a long period fruitfully treated 'native' victims, continued their practices unabated among countrymen despite the triumphant march of Western medicine.[14] Interestingly, these skilled snakebite-curers were negated by the colonisers as ordinary 'magicians' or 'sorcerers' or mere 'snake charmers' who were 'exceedingly dexterous' to 'handle poisonous snakes freely and without fear even when in possession of their fangs' (Fayrer 1872, 149). According to the colonial account, these 'native' healers were well aware of the danger, and knew 'perfectly well that no antidote has any effect', though cleverly pretended to 'prevent or cure bites by roots and snake-stones' (Fayrer 1872, 149). Therefore, it is quite natural that despite their 'wizardry' skill in 'black magic' and performance of 'mysterious rites' they were not able to save snakebite victims from deaths (Somerville 1931, 74–77). Thus the colonial accounts absolutely nullified any possible existence of rationale behind the medical practice of 'native' doctors. To the colonisers, these indigenous snakebite-curers were only 'mystery men'(Somerville 1931, 75) and were never treated as a 'gentlemen' physicians however skilled they might have been. This indicates that, there was a strong Western sense of cultural superiority which perhaps boosted the colonisers to attain a position of mentors possessing accurate knowledge of the Orient and therefore competent to judge whatever Oriental, particularly the traditional healers of the East and their 'ignorant' patients.

[14] As we see, in nineteenth-century Bengal, lots of vernacular medical texts began to be published, which dealt with cure of snake poisoning through traditional method. In these texts, Bengali healers often pleaded for revitalisation of ancient medical heritage of snakebite-cure. See Ray 1887; Ray 1897; Siddhanta 1897.

Actually, European practitioners were always inclined to depend on their own 'scientific' endeavour which allowed them to negotiate from 'a vantage point and with a clarity, determination and aggression which his "native" opponent could hardly match' (Kumar 2006, 33).

European medical practitioners arrogated to themselves complete monopoly of the authoritative knowledge of the diseases of hot climates including envenomation by Indian snakes, precisely because of their belief that Europe only possessed the universal knowledge to comprehend and control the limits of the world. On 22 July 1809, Civil Surgeon John Macrae proudly wrote to John Fleming, President of the Medical Board of Fort William, that he was fortunate to possess adequate knowledge of Western medicine, which 'happily counteracted' the fatal effect of the 'disease in the human body, consequent to the bite of the serpent' (Macrae 1810, 309). Indeed, by that time, most European doctors in India became confident that they alone could master such cruel disease of the colony and this confidence rapidly spread among western practitioners working in the whole of non-European world. After conducting a dozen of experiments on the effect of snake venom on some robust dogs, one of them wrote in an article in the *Asiatick Researches*:

> I am therefore still of opinion, that the (Western) method of cure mentioned in the foregoing paper is the most rational, and the most likely to succeed in preventing death, as well as the other bad consequences which sometimes follow the bite of a serpent that is not mortal. In the use of the nitric acid bath, I should have much confidence: and this confidence arises from a greater experience of its powerful influence upon the human body in different diseases: this experience will soon be communicated to the public by my friend Mr. SCOTT, whose labours in the application of a most powerful and useful agent in medicine, and especially useful as applied to the inhabitants of warm climates, merit the greatest praise (Boag 1799, 125–126, Parenthesis added).

Thus tropical medicine and subsequent healthcare strategy, in course of healing the sick, also became a symbol of superiority to justify the colonisers' mastery over the 'inhabitants of warm climates'. Indeed, the hegemonic power of Western medical knowledge provided the colonisers an opportunity to explain the indigenous inhabitants as naturally inferior and backward and also mark the prevailing indigenous healthcare system as utterly unscientific and ineffective.

Perhaps, the disease of snake poisoning had thrown a moral challenge to the colonial physicians and they evidently saw themselves as saviours, religiously responding to the call of the helpless indigenous people facing probable death by snake poisoning and were proud to take charge of the 'terror' of the disease. For example, one of the esquires of the EEIC, John Williams vividly narrated over half a dozen cases of snakebites between August 1780 and September 1788 where all

the victims were invariably 'native' people (Williams 1790). In his view these Indians seemed to be the 'white man's burden', entirely dependent for their survival on British rational thinking and medical practice; as if the 'white man', was morally obliged to rescue and civilise them. In the narration of this British medical practitioner, the natives were portrayed as first applying their own process of 'Prayers and superstitious incantations' (Williams 1790, 255) to get cured of venom and when failed miserably, desperately approached Williams, who easily saved their lives with few drops of medicine. About one such incident in July 1782, Williams wrote:

> On being informed of the accident (of a Hindu Brahmin woman), I immediately sent a servant with a bottle of the Volatile Caustic Alkali Spirit, of which he poured about a teaspoonful, mixed with water, down her (a Hindu Brahmin woman) throat, and applied some of it to the part bitten. The dose was repeated a few minutes after, when she was evidently better, and in about half an hour was perfectly recovered.
> This accident happened in a small hut, where I saw the snake, which was a middle-sized *Cobra de Capello*. The *Bráhmens* would not allow it to be killed. In the above case, no other means whatever were used for the recovery of the patient than are here recited (Williams 1790, 255, Parenthesis added).

Thus excellence, expertise and effectiveness of Western medicine and health policy, as intended by Williams, were forcefully established and after successfully applying a reviving remedy he bragged: 'it points out the means of obtaining the greatest self-gratification the human mind is capable of experiencing; that of the preservation of the life of a fellow-creature, and snatching him from the jaws of death' (Williams 1790, 254). This account paints the Indian 'fellow creature' as extremely helpless before the 'jaws of death' and glorifies the greatness of the alien protector, a knowledgeable British physician, who salvaged these feeble 'native' people by few drops of Western medicine. The victory of Western medical science over the diseases of snake poisoning in the tropical landscapes was thus projected and also justified.

CONCLUSION

This paper shows that the British imagination of the snake infested Orient/tropics and colonial medical studies regarding snakes and their venoms were often laced with a sub-terranial discourse of colonial difference. Presence of numerous venomous snakes causing substantial deaths due to snakebite envenomation was often characterised as marker of environment that was

essentially an ‘Other’. This Otherness rubbed off on the venomous snake species of India as well and they came to be represented essentially as ‘terror’; snakes became particularly emblematic of ‘disorder’. We argue that in expressing the condition of snake-ridden tropics or the Orient as ‘wild’ through certain metaphors and tropes, Western medical practitioners simultaneously underwrote their positional superiority of being denizens of civilised and enlightened Europe and, in doing so, they constructed the entire tropical landscape as colonisable Other. In this context, Western/tropical medicine and healthcare system became the symbol of ‘superiority’ on which the colonisers justified their mastery over the ‘inhabitants of warm climates’ and wilfully discarded all traditional local knowledge that might–of course, if properly evaluated and developed–have helped them in coping with the disease of snake poisoning. Thus, colonial medical engagement with venomous snakes and consequential health measures, which flourished under British agency, provided the tools to order and control the snake-ridden landscape of India and paved the way for the assertion of an intellectual superiority over the colonised people. In this regard, we can say that Western medicine and public health work, not only as practice but also as ideology, served to justify the colonial rule and became a true instrument of the British Indian Empire.

There is no paradox that, the Orientalist mechanism of ‘knowing’ the venomous snakes and the inhabitants of snake-infested country, enabled European intellectual mastery over the tropics and inevitably furthered the colonial presence in tropical India. But, it is also mentionable here that British management of Indian snakes and their venoms in early colonial period had not followed a strong way of coercion like colonial policies of quarantine and vaccination schemes (see Arnold 1993; Harrison 1994), and therefore did not become a constant site for ‘native’ unrest and resistance. Socio-culturally Indians remained intimately associated with snakes and their medical engagement with snakebites which was varied and traditionally enriched also continued at least in the remote areas. It was on a later occasion when Indians protested against the extensive state-sponsored bounty-killing of snakes during the last quarter of the nineteenth century. This was an endeavour taken by the colonial government as a means of dealing with the problem of snakebite deaths as the long-drawn medical research in India failed to find any effective antidote till date–an interesting issue which received only scarce attention in recent historiography (see Chakrabarti 2012, 124–127). The debate over the large-scale uses of animals including snakes and their vivisection in colonial laboratories also remains to be taken up as a legitimate area of detailed study. However, the present paper has studied snakes and snakebites in early British India as a lens through which it has tried to offer some insights for future research and discussion.

REFERENCES

ANONYMOUS. (1876). *India: Illustrated*. New York: Dodd, Mead, and Company.

ARNOLD, D. (1989). Introduction: Disease, Medicine and Empire. In D. Arnold (Ed.), *Imperial Medicine and Indigenous Society*. Delhi: Oxford University Press. 1–26.

ARNOLD, D. (1993). *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*. Berkeley and London: University of California Press.

ARNOLD, D. (1996a). Introduction: Tropical Medicine before Manson. In D. Arnold (Ed.), *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500–1900*. Amsterdam and Atlanta: Rodopi Press. 1–19.

ARNOLD, D. (1996b). *The Problem of Nature: Environment, Culture and European Expansion*. Oxford: Blackwell Publishers.

ARNOLD, D. (2005). *The Tropics and the Travelling Gaze: India, Landscape, and Science 1800-1856*. Delhi: Permanent Black.

BALA, P. (1991). *Imperialism and Medicine in Bengal: A Socio-Historical Perspective*. New Delhi: Sage Publication.

BISWAS, A. (Ed.), (2009). *Vijay Gupter Manasā Maṅgal* (*Manasāmaṅgal by Vijay Gupta*). Kolkata: Anjali Publishers.

BHATTACHARYA, A. (2006). *Folklore of Bengal*. New Delhi: National Book Trust.

BHATTACHARYA, B. (Ed.), (1961). *Ketakādās Kṣemānanda Manasāmaṅgal* (*Manasāmaṅgal by Ketakādās Kṣemānanda*). New Delhi: Sahitya Akademi.

BHATTACHARYYA, A. (Ed.), (1962). *Bāiś Kabir Manasā-Maṅgal Ba Bāiśa* (*Manasāmaṅgal by Twenty-two Poets*). Calcutta: Calcutta University Press.

BHATTACHARYYA, A. (1970). *Bānglā Maṅgalkāvyer Itihās* (*History of Bengali Maṅgalkāvya*). Kolkata: A. Mukherjee and Co. Pvt. Ltd.

BHAUMIK, R. (2011). Ophiology of India: Snakes, Colonial Medicine and Orientalism. *International Journal of Physical and Social Sciences*. Vol. 1 (3). 35–63.

BHAUMIK, R. (2012). The Natural History of Indian Serpents: Dr. Patrick Russell, Colonial Medicine and the British Empire. *History Studies: International Journal of History*. Vol. 4 (4). 170–193.

BHISHAGRATNA, K. K. (Trans.), (2012). *Suśruta Saṁhitā: Text with English Translation, A Full and Comprehensive Introduction, Additional Text, Different Readings, Notes, Comparative Views, Index, Glossary and Plates*. Vol. 3. Varanasi: Chowkhamba Sanskrit Series Office.

BOAG, W.(1799). On the Poison of Serpents. *Asiatick Researches*. Vol. 6. 103–126.

CHAKRABARTI, P. (2012). *Bacteriology in British India: Laboratory Medicine and the Tropics*. Rochester, NY: University of Rochester Press.

CHAUDHURI, B. B., BANDOPADHYAY, A. (Eds.), (2004). *Tribes, Forest and Social Formation in Indian History*. New Delhi: Monohar.

CORBETT, J. (1968). *My India*. Madras: Oxford University Press.

CURTIN, P. D. (1989). *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century*. Cambridge: Cambridge University Press.

DA ORTA, G. (1913). *Colloquies on the Simples and Drugs of India*. London: Henry Sotheran and Co.

DAVY, J. (1820). Analysis of the Snake-Stone. *Asiatick Researches*. Vol. 13. 317-328.

DEORAS, P. J. (1978). *Snakes of India*. New Delhi: National Book Trust.

DIMOCK, E. C. (1962). The Goddess of Snakes in Medieval Bengali Literature. *History of Religions*. Vol. 1 (2). 307-321.

DIMOCK, E. C., RAMANUJAN, A. K. (1964). The Goddess of Snakes in Medieval Bengali Literature. Part II. *History of Religions*. Vol. 3 (2). 300–322.

DRAYTON, R. (2005). *Nature's Government: Science, Imperial Britain, and the 'Improvement' of the World*. New Delhi: Orient Longman.

FAYRER, J. (1872). *The Thanatophidia of India being a Description of the Venomous Snakes of the Indian Peninsula, with an Account of the Influence of their Poison on Life and a Series of Experiments*. London: J. and A. Churchill.
FAYRER, J. (1878). *Destruction of Life by Wild Animals and Venomous Snakes in India*. London: Royal Society of Arts.
FAYRER, J. (1882). Destruction of Life in India by Poisonous Snakes. *Nature: A Weekly Illustrated Journal of Science*. Vol. 27 (687). 205–208.
HEBER, R. (1829). *Narrative of a Journey through the Upper Provinces of India, from Calcutta to Bombay, 1824–1825, with Notes upon Ceylon, an Account of a Journey to Madras and the Southern Provinces, 1826, and Letters Written in India*. Vol. 1. Philadelphia: Carey, Lea and Carey.
HARRISON, M. (1992). Tropical Medicine in Nineteenth-Century India. *The British Journal for the History of Science*. Vol. 25 (3). 299–318.
HARRISON, M. (1994). *Public Health in British India: Anglo-Indian Preventive Medicine 1859–1914*. New Delhi: Cambridge University Press.
HARRISON, M. (1999). *Climates and Constitutions: Health, Race, Environment and British Imperialism in India, 1600–1850*. New Delhi: Oxford University Press.
HEADRICK, D. R. (1981). *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*. New York and Oxford: Oxford University Press.
JEFFERY, R. (1988). *The Politics of Health in India*. Berkeley and Los Angeles: University of California Press.
KUMAR, A. (1998). *Medicine and the Raj: British Medical Policy in India, 1835-1911*. New Delhi: Sage Publications.
KUMAR, D. (Ed.), (2001). *Disease and Medicine in India: A Historical Overview*. New Delhi: Tulika Books.
KUMAR, D. (2006). *Science and the Raj: A Study of British India*. New Delhi: Oxford University Press.
KUMAR, D., BASU, R. J. (Eds.), (2013). *Medical Encounter in British India*.New Delhi: Oxford University Press.
KIPLING, R. (2015). *The Jungle Book*.London: Puffin Books.
MACKENZIE, W. (1820). An Account of Venomous Sea Snakes, on the Coast of Madras. *Asiatick Researches*. Vol. 13. 329–336.
MACRAE, J. (1810). Case of the Bite of a Poisonous Snake Successfully Treated. *Asiatick Researches*. Vol. 11. 309–317.
MAITY, P. K. (1966). *Historical Studies in the Cult of the Goddess Manasā: A Socio-Cultural Study*. Calcutta: Punthi Pustak.
MEDICAL AND PHYSICAL SOCIETY (1830). Proceeding of Medical and Physical Society. *Gleanings in Science*. Vol. 2. 135–136.
MEHTA, P. M. et al. (Eds.), (1949). *The Caraka Saṃhitā: Expounded by the Worshipful Ātrèya Punarvasu Compiled by the Great Sage Agnivèśa and Redacted by Caraka and Dridhabala*. Vol. 4. Jamnagar: Shree Gulabkunverba Ayurvedic Society.
METCALF, B. D., METCALF, T. R. (2008). *A Concise History of Modern India*. New Delhi: Cambridge University Press.
METCALF, T. R. (1998). *Ideologies of Raj*. New Delhi: Cambridge University Press.
OLDHAM, C. F. (1905). *The Sun and the Serpent: A Contribution to the History of Serpent-Worship*. London: Archibald Constable and Co. Ltd.
PALIT, C., DUTTA, A. K. (Eds.), (2005). *History of Medicine in India: The Medical Encounter*. Delhi: Kalpaz Publications.
PATI, B. (Ed.), (2011). *Adivasis in Colonial India: Survival, Resistance and Negotiation*. New Delhi: Orient BlackSwan.
PATI, B., HARRISON, M. (Eds.), (2006). *Health, Medicine and Empire: Perspectives on Colonial India*. New Delhi: Orient Longman.
PATI, B., HARRISON, M. (Eds.), (2009). *The Social History of Health and Medicine in Colonial India*. London and New York: Routledge.

POOL, J. J. (1894). *Half Hours with the Hindus*. London: Ward, Lock, and Bowden, Ltd.

RANGARAJAN, M., SIVARAMAKRISHNAN, K. (Eds.), (2012). *India's Environmental History: Colonialism, Modernity, and the Nation: A Reader*. Ranikhet: Permanent Black.

RAY, K. L. (1897). *Sarpāghāter Cikitsā* (*Treatment of Snakebite-Injury*). Kolkata: Author.

RAY, T. (1887). *Sarpadaṃśan Cikitsā* (*Treatment of Snakebite*). Kolkata: Yadav Chandra Lahiri.

REID, H. A. (1976). Adder Bites in Britain. *British Medical Journal*. Vol. 2 (6028). 153–156.

RIVETT-CARNAC, J. H. (1879). *Rough Notes on the Snake Symbol in India, in Connection with the Worship of Siva*. Calcutta: The Asiatic Society of Bengal.

RUSSELL, P. (1796). *An Account of Indian Serpents, Collected on the Coast of Coromandel; Containing Descriptions and Drawings of Each Species; together with Experiments and Remarks on their Several Poison*. London: W. Bulmer & Co. Shakspeare Press.

SAID, E. W. (2001). *Orientalism: Western Conceptions of the Orient*. New Delhi: Penguin Books.

SEN, S. (Ed.), (1953). *Vipradāsa's Manasā-Vijaya: A Fifteenth Century Bengali Text Edited with a Summarised Translation, Notes and Glossary and with an Introduction on the Literature, Myth and Cults Relating to Manasā*. Calcutta: The Asiatic Society.

SEN, S. (Ed.), (1968). *Viṣṇu Pāla's Manasā-Maṅgala*. Calcutta: The Asiatic Society.

SHARMA, J. (2012). *Empire's Garden: Assam and the Making of India.* Ranikhet: Permanent Black.

SHARMA, M. (2012). *Indigenous and Western Medicine in Colonial India*. New Delhi: Foundation Books.

SIDDHANTA, R. C. (1897). *Sarpāghāt Cikitsāsār* (*A Compendium of Treatment for Snakebite-Injury*). Kolkata: Sarada Prasad Sen.

SINHA, B. C. (1979). *Serpent Worship in Ancient India*. New Delhi: Books Today.

SLOUBER, M. (2017). *Early Tantric Medicine: Snakebite, Mantras, and Healing in the Gāruḍa Tantras*. New York: Oxford University Press.

SMITH, W. L. (1980). *The One-eyed Goddess: A Study of the Manasā-Mangal*. Stockholm: Almqvist and Wiksell International.

SOMERVILLE, A. (1931). *Crime and Religious Beliefs in India*. Calcutta: The Criminologist.

SWAROOP S., GRAB, B. (1954). Snakebite Mortality in the World. *Bulletin of the World Health Organization*. Vol. 10 (1). 35–76.

TAVERNIER, J. B. (1889). *Travels in India*. Vol. 2. London: MacMillan and Co.

VOGEL, J. P. (1926). *Indian Serpent-Lore or the Nagas in Hindu Legend and Art*. London: Probsthain.

WARRELL, D. A. (2005). *Guidelines for the Clinical Management of Snake Bites in the South-East Asia Region*. New Delhi: World Health Organization.

WILLIAMS, J. (1790). On the Cure of Persons Bitten by Snakes. *Asiatick Researches*. Vol. 2. 254–258.

WORBOYS, M. (1976). The Emergence of Tropical Medicine: A Study in the Establishment of a Scientific Specialty. In G. Lemaine, R. MacLeod, M. Mulkay and P. Weingart (Eds.), *Perspectives on the Emergence of Scientific Disciplines*. The Hague: Mouton. 75–98.

WORBOYS, M. (1988). Manson, Ross and Colonial Medical Policy: Tropical Medicine in London and Liverpool, 1899–1914. In R. MacLeod and M. Lewis (Eds.), *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion*. London and New York: Routledge. 21–37.

WORBOYS, M. (1993).Tropical Diseases. In W. F. Bynum and R. Porter (Eds.), *Companion Encyclopedia of the History of Medicine*. London and New York: Routledge. 512–536.

PLASTIC SURGERY PHENOMENON AMONG SOUTH KOREAN WOMEN. THE INSTRUMENTAL BODY IN A RITE OF PASSAGE TO THE NORMATIVE "INNOCENT GLAMOUR"

CARMEN VOINEA*

ABSTRACT

The study explores the plastic surgery phenomenon among young South Korean women and aims to depict the motivations of women as agentic subjects and social pressures that lead them to undergo facial modification. The research consisted of direct observation between 2008–2009, in Daegu (South Korea) and continued in Bucharest (Romania) in 2011, with a group interview followed by individual structured interviews with four South Korean students. The study additionally includes mass-media and pop culture analysis, secondary statistical analysis, and literature review. This research suggests that their motivations are derived from a pragmatic, instrumentalist view of the body as a vehicle for success in life, with two main goals: professional and personal. It is also argued that the social pressures of a collectivistic, competitive, consumer society that upholds a very strict and almost singular standard of beauty, has a normalization force on women's bodies. I want to depart from the view that the change is done towards a Caucasian ideal and argue that modern South Korea has given birth to its own blend of a beautiful body, a "V-line", "Innocent Glamour" that mixes Caucasian and local aesthetic physical traits. This blend's characteristic is that South Korean standard of beauty converges to an innocent look. The women undergoing surgery are embodied selves in transition, they are preparing their personal narrative of success and transformation, performing this practice at key moments in their lives, as a rite of passage to maturity. Plastic surgery can be viewed as an expression of the right to beauty that, in the South Korean context, can be equated to the right to succeed.

Keywords: *plastic surgery, South Korea, racial discourse, rite of passage, standards of beauty.*

---

* PhD student at the Faculty of Sociology and Social Work, University of Bucharest.

Rom. Jour. of Sociological Studies, New Series, No. 1, p. 69–87, Bucharest, 2017

Creative Commons License
Attribution–NoDerives CC-BY-ND 4.0

INTRODUCTION

Statistics regarding the number of people undergoing plastic surgery in South Korea rely mainly on surveys due to the fact that the majority of the procedures take place in private clinics from which records are not easily available and the market is poorly regulated. However, the surveys capture the same fact: the worldwide leading position the country holds at the number of cosmetic surgeries per capita. To cite only a few such data: in 2010, there were 361,988 cosmetic procedures performed in South Korea, with one in five women from Seoul opting for plastic surgeries; furthermore, a study from 2009 surveying 2041 female university students indicated that 1 in 4 had had eyelid surgery with a percentage of 80% showing "their willingness to undergo cosmetic surgery in the future" (Moon, 2015, p. 102). A BBC poll estimated that, in Seoul, at least 50% of women in their twenties had altered their body using these practices, while the men "make up fifteen per cent of the market, including a former President of the country, who underwent double-eyelid surgery while in office" (Marx, 2015). According to the information released in 2011 by the International Society of Aesthetic Plastic Surgeons (ISAPS) and published by Seoul TouchUp (a government-approved medical tourism agency in Korea), 13 out of 1000 Koreans have undergone plastic surgery (South Korea, SeoulTouchUp, 2014). To put it into a global context, South Korea was on the 4th place regarding total surgical procedures performed in 2015, after USA, Brazil, and Mexico (ISAPS, 2016) and on the third place at the number of face and head procedures after Brazil and USA (ISAPS, 2016); facial interventions being the most popular in South Korea as we will also see further. There are no statistics released by ISAPS regarding the ranking based on the number of plastic surgeries per capita, but what can be easily noticed is that all countries with higher number of procedures have a population at least double that of South Korea.

Drawing on scientific literature ranging from diverse fields of knowledge such as sociology, anthropology, history, or feminist studies and dating back especially from the past 40 years since the body started getting its long awaited place in the academy, I explore the motivations and social pressures behind young Korean women's decisions to undergo, in such high numbers, cosmetic surgery for facial modification. I suggest that their motivations are derived from a pragmatic, instrumentalist view of the body as plastic, an easily alterable possession and a vehicle for success in life, with the two main goals being professional (securing a good job) and personal (fulfillment through a happy marriage). Suggestive of this is the split between "marriage cosmetic surgery" and "employment cosmetic surgery" in Korea (Holliday and Elfving-Hwang, 2012, p. 74), a distinction that emphasizes the two main goals for which the body is modified. Placing this instrumental view of the body in the debate regarding agency versus structure in body modification, the women's motivations position them as agentic subjects in

control of the body. However, at the same time, women also conform to structure (conceptualized here as social pressures) that holds a normalization force on women in the context of a collectivistic, yet very competitive society, which underwent a fast paced modernization; a society that still embeds neo-Confucianism traits and upholds a very strict and almost singular standard of beauty. As the majority of the Western (and even a large portion of Korean) discourse about plastic surgery implies the change is done towards a Caucasian ideal, I want to depart from this simplistic view and claim that modern Korea has given birth to its own blend of ideal beautiful body, a "V-line", "Baby face" that mixes Caucasian traits (high nose, big eyes) and local aesthetic images, like a pointy chin, or "love bands" (under eye bags, aegyposal – *애교살*). researchI am in line with the findings presented by Holliday and Elfving-Hwang (2012) who rebut the claim that Koreans alter their body to look more Occidental. Additionally, I stress that the Korean ideals of beauty converge towards a more innocent look, compared to the allegedly sexual image in the West. However, underneath all these there lies a strong teleological component: going through cosmetic surgery, the young Korean women are preparing for the next phase in their lives. The surgery is a rupture point between their old not so attractive, with its unaccomplished old self, unmarried and not yet professionally fulfilled; and the new embodied self adequately equipped for the new phase in life. The women opting for surgery therefore become embodied selves in transition; they are studied at key moments in their lives, preparing for the rite of passage to maturity and preparing their personal narrative of transformation and success. Here I draw on Schouten's selves in transition theory which has analysed the consumption of plastic surgery in the context of identity construction and rites of passage (1991, p. 412). Following the tradition of Arnold van Gennep and Victor Tuner but applied to a secular Western world, Schouten sees plastic surgery as a "self-imposed, personal rite of passage", around a period of liminality (1991, p. 421). What differentiates my view is that I don't see the process of body modification as a strict self-imposed, affirmation of the self, but one that also needs to conform to the structural pressures in the Korean collectivistic society. In the interviews I held and from the conversations with the college students, there was a general consensus that women, more than men, are required by society to look good in order to offset their career, to be more popular and therefore have better chances of finding a husband.

To a more macro level, the busy streets of Korean cities are mirrors of Korean society as whole, they bear the marks of the recent fast paced modernization, a hyper-consumerist reality that still incorporates aspects of their long lasting history and tradition. So as these streets are a synecdoche of the Korean society, so too the plastic body of Korean women (modified via cosmetic surgery) is a synecdoche of the highly transformational societal changes through which South Korea has passed in its journey from the hermit kingdom to modernization and onto the global stage.

METHOD

The research started in 2008 and continued, for one year, during which time the investigator lived in Daegu (South Korea); information was gathered by direct observation framework. The majority of the data collected was based on conversations with college students (over twenty students, during the course of six months), the vast majority young women 18 to 30 years old studying tourism at Yeungjin college in Daegu. In addition to the daily conversations, a rich source of information was the "self-introduction notebooks" that each student had to present, as part of their course work, to the investigator, an English teacher's assistant. These provided insight into the way they defined themselves and how much emphasis was put on physical appearance each notebook contained self-evaluations of their body and even of the family members. I want to note that the format of the notebooks and categories of information it contained selected by the students themselves; the fact that all included a physical traits' description by their own choice comes to stress the point that the students I worked with put great value on appearance.

The second part of the research took place in 2011 and included a mixed gender group interview with four Korean students (20 to 30 years old; none, however, being subject to plastic surgery) studying in Bucharest that was followed up with four individual structured interviews. The group interview method as I wanted to also capture the social pressures derived from a collectivistic mindset that might appear when the subjects are discussing the topic with other people present. However, there was no influence on the patients group responses compared to the individual ones, the main reason being a general consensus regarding the motivations for undergoing plastic surgery (for career and personal life). Also, neither of the subjects voiced an intention to undergo plastic surgery in the future although most had acquaintances or friends who did. The selection of the subjects was done via convenience sample, introduced to me by a mutual acquaintance. The study additionally includes mass-media and pop culture analysis (news, blog posts, and comments to these materials; TV shows, and movies) and secondary statistical analysis, as well as literature review regarding racial discourse, Korean standards of beauty and mass-media influence on plastic surgery.

LITERATURE REVIEW

The modern body in David le Breton's (2002) view is defined by the rupture between the subject and itsself, the individual will possess the body, more than actually being a one (Breton, 2002, p. 5). He pinned the first significant blow to the holistic view of the body as one with nature, characteristic to the traditional societies, to the work of the anatomist Vesalius and his contribution on dissection;

the second breaking point was the Cartesian dualism doctrine, defined by superiority of mind over matter. The Cartesian dualism that separates the mind from the body and places the former in a dominant position had gathered an academic consensus and was until recently the dominant theoretical view on the body (Breton, 2002, p. 54; Corbin, Cortine, and Vigarello, 2009). Furthermore, as the mind breaks with its material embodiment, so do societies depart from their traditional frame and enter modernity.

In the twentieth century, however, the body as uncontested host of the soul and mind has been restored to its crucial role in understanding the world, and many voices from various fields in the academia started the Cartesian dualism. From Maurice Merleau-Ponty's work who viewed it as "our general medium for having a world", to Freud's "body-ego", Edmund Husserl's phenomenological body as "zero-point of orientation", and Marcel Mauss' techniques of the body, it is the last century that marks the theoretical invention of the body as Courtine describes it (2009, p. 5). If we add to the equation the advances in medicine, the consumer society, the state's ever growing interest in the health of its subjects, and the right to health inscribed in the Universal declaration of human rights, in modernity, social progress found its object in the body, more than in the social and political realm as it did in the past (Negrin, 2002; Hogle, 2005). Consequently, plastic surgery follows in the same lines:

"As Sander Gilman points out (1999: 19), with the development of cosmetic surgery at the end of the 19th century, the Enlightenment belief in the ability of individuals to transform themselves, which had originally been articulated as a social and political task, came to be redefined in biological and medical terms. This had the effect of shifting the locus of change from the transformation of social structures to transforming the body itself." (Negrin, 2002, p. 25) It is this transformational power of plastic surgeries and the promise of social and personal fulfillment that is transparent in the interviews and conversations I had with Korean women who choose these practice.

A major contribution to the sociology of the body came from feminist studies and, especially pertaining to the cosmetic surgery phenomenon among young women, feminism was one of the richest sources of research. If we accept Shelley Budgeon's statement that women "have always been more embodied than men because of the association of the feminine with the body" (2003, p. 38), modernity marked an emancipatory moment for both women and the body, as Baudrillard concisely argues: "Now, just as women and bodies were bound together in servitude, the emancipation of woman and the emancipation of the body are logically and historically linked (for related reasons, the emancipation of the young is contemporaneous with them)" (2008, p. 177).

The works of Susan Bordo, Deborah Caslav Covino, Debra Gimlin, Cressida J. Heyes, Meredith Jones (Featherstone, 2010, p. 202), or Kathy Davis brought significant contributions to the study of cosmetic surgeries. Furthermore, this

subject sparked debate regarding how these bodily practices are actually empowering women as a sign of self-realization and agency as Davis (Koo, 2004, p. 45) had suggested; a vision criticized by Susan Bordo, among others, who had claimed that women are merely conforming to the existing cultural norms in a normative patriarchal society. In a later work, Kathy Davis (2003) argued that she was refusing to consider women undergoing surgery as "cultural dopes", but rather to position "them as "competent actors", with an "intimate and subtle knowledge of society," including the "dominant discourse and practices of feminine beauty" (Davis, 2003, p. 13). I would however like to depart from this rather theoretical dispute about the definition of "agency", and stand by Cressida J. Heyes' moderate view, in which the cosmetic surgeries women choose to undergo "both constrains (by compelling compliance with the norm) at the same time as it enables (by making certain forms of subjectivity possible), and, indeed, these two functions cannot be clearly separated." (2008, p. 55)

Besides the feminist ramification of the plastic surgery discussion, another area of research on plastic surgery is the racial discourse associated with it. We owe key contributions to this subject to Gilman, Kaw (1993), or Haiken (1997). That plastic surgery is intertwined with the racial discourse seems to be an uncontested fact as shown in the findings of Haiken (1999, p.18) who links the two from the beginning of this body technique in modernity, in late 19th century, when American surgeons started experimenting on correcting the "Jewish nose". The World War I reconstructive surgeons started using their experience from the battlefield in correcting physical features in times of peace. Another fact that helped the development of this practice in the U.S. were the waves of immigration from Europe (especially the eastern and southern parts) that brought to the surgical discourse other "abnormal" features carried by the migrating bodies of Italians, Armenians, Greeks, Iranians, and Lebanese, who became potential patients in a desire for "ethnic anonymity" (Haiken, 1999). It is no wonder that the United States with the diversity of races striving for assimilation in the dominant culture is the birth place of plastic surgery. The World War II and its economic boom marked the beginning of a constant growth in cosmetic surgeries, while the ever growing consumer society became the ideal frame to foster such practices.

The motivations of the Asian American women interviewed by Kaw (1991) in choosing plastic surgery confirm the racial component, as they subject themselves to bodily change to "escape racial prejudice that correlates their stereotyped genetic physical features ("small, slanty" eyes and a "flat" nose) with negative behavioral characteristics, such as passivity, dullness, and a lack of sociability" (1991, p. 75). Medicine, as the means through which the modification is done, is perpetuating and legitimizing these prejudices, a conclusion that is also among my findings, of course in a different macro context and with a similar concept replacing Kaw's prejudices: social pressures.

The bulk of the literature I consulted comes from the Western academic environment and I must warn about the inadequacies that might appear when applying this framework to non-Western cultures such as Korea. However, in discussing the recent social and cultural realities regarding the cosmetic surgery phenomenon, I will try to shift the focus towards a predominantly Asian literature. To summarize, from the Western school of thought I take the modern view of the body from Turner as no longer the fixed object (cited in Gremillion, 2005, p. 14) from the traditional society; the body is no longer "a biological given whose organic integrity is inviolable" (Negrin, 2002, p. 29). The body, I argue, becomes a possession of the individual and it is instrumental in the affirmation of the self, but also holds a normative function used to conform to the social standard. We can find similarities between the modernization project in the West and that in Korea in regards to this particular view of the body, as ruptured from tradition. The fast paced modernization in Korea made the body plastic, an object at the disposal of the individual, who thanks to the hyper-consumer society possesses the means through which to modify it and eagerly does so to reflect the standards of a conformist, collectivistic Korean society. A difference to the western modern societies is the pervasive remnants of the traditional Korea (especially through neo-Confucian morals) that allowed the creation of its special blend of bodily images, different from the Western ones but still importing some essential occidental traits. As the passage to modernity changes the view on the body, so too individuals transform their bodies through plastic surgery as a rite of passage to the new socially conform, prepared for success self.

HISTORICAL OVERVIEW OF THE EVOLUTION OF KOREAN BEAUTY STANDARDS

That modern day Korea is a highly competitive society is an uncontested fact; young people and their parents are preparing them to succeed, not only by investing in education, but also by trying to improve other aspects that might influence a person's success in life. In Korea people are judged based on their physical appearance and this becomes a key factor in building a career. A survey lead by a recruitment agency JobKorea "found that 80 percent of recruitment executives considered the physical appearance of a candidate 'important', and a 2006 study found that there was a perception among high school students that appearance would often be considered of greater importance than abilities and skills in hiring decisions (Jung and Lee, 2006)" (Holliday and Elfving-Hwang, 2012, p. 74). Korea is not only a competitive environment, it is also a collectivistic society, and the toll taken on how young women need to present themselves is therefore significantly higher. Among the findings of my research I already indicated that it is more important for women to look good than for men. If

everyone is trying to look as good as they can to have the best chances, the collectivistic pressures make women need to conform to the very high standard of beauty in order not to stand out in an inferior way. A cross-cultural study analyzing the importance of physical appearance for women in South Korea and U.S. indicated that "appearance is considered highly important for the evaluation of the self and others for women in a collectivistic culture. Women are often evaluated by their physical appearances rather than by their abilities or skills they have" (Jung and Lee, 2006, p. 363).

It is necessary at this point to give a short historical overview of how the modern body image is rooted in Korea's past. Since the end of the 19th century, when the "hermit kingdom" entered the global stage, Korean bodies became acquainted with non-Asian corporeal images and, through this mirror, they began re-assessing their own body. The traditional standard of beauty for women was "moderately plump with fair skin, cultivated mannerisms and modesty, with a cultural emphasis on inner-beauty" (Jung and Lee, 2009, p. 283). If in the 1890s the "westerners' `big bright eyes, high nose, large ears and thick lips' were a cause of fear to Koreans and brought about of their being cannibals (Naw, 1898)" (Yoo, 2001, p. 431), during the colonial period the facial beauty standard started incorporating western traits:

"Criteria for a beautiful face, `wide forehead, short lashes and moderate nose' before, now became those of a western beauty, `shallow forehead, double eyelid, long lashes and high nose'. For a beautiful body, too, while it was `slender waist, small feet and small hands' that counted in the past, it was now `large hands and feet, tall height and sporty body' (Dong-A Ilbo 11 April 1926). This was how a newspaper came to run an article on medical surgery for creating double eyelids, under the title, `Ways to make ugly eyes beautiful' (Dong-A Ilbo 25 February 1927)" (Yoo, 2001, p. 431).

Korea's encounter with the Western world was also a moment of realizing their society's backwardness and U.S., in particular, became the standard of a flourishing, rich, modern nation. The western cultural superiority can also be traced to the work of the missionaries who were the first to bring modern education and western medicine to Korea (Yoo, 2001, p. 427), (Park, 2006). The Korean "modern boys" and "modern girls" that started mimicking, at bodily level the Occidental fashion and customs, became the drivers of modernization, what the Korean intellectuals described as "Americanism" (Yoo, 2001, p. 423).

These changes are, however, not limited to adopting western fashion and hair styles, they are representative of a shift in how Koreans perceive the body. From the Neo-Confucian traditional view of the body as sacred (Kim, 2003, p. 98), young Koreans in the colonial period now used it as a sign of showing their willingness to modernize. The rupture that starts taking place in Korea, is an equivalent of what the Cartesian dualism was for the western world. As Yoo claims, the modernization of the body was "carried out on three levels: to replace

the traditional aesthetics, to westernize the appearance, to liberate the bodily movements closely regulated by the Confucian norms." (2001, p. 425-426) It is however, a change that did not come from within, but from the outside, from a culturally dominant society - the U.S. - and this might be one of the reasons for the mix of Caucasian traits found in the standards of beauty in today's Korea.

Kim (2008) and Haiken (1999) see the Korean War as another breaking point for the integration of western images in the Korean view of the body. The work of surgeon David Ralph Millard, Jr., who had been stationed in Korea, opened the way for "normalizing" the "Oriental eye". He wrote in his journal: "The absence of the palpebral fold produces a passive expression which seems to epitomize the stoical and unemotional manner of the Oriental" (Millard, 1964, p. 647)." (Kaw, 1991, p. 82). He was subjected to criticism, especially from the leftist movements, but legitimized his practices with the fact that they were requested by the patients themselves for socioeconomic reasons, local beliefs and superstitions and that Asian surgeons were also performing it (Haiken, 1999, p. 47). Decades before the boom of the plastic surgery phenomenon in Korea, the body was an instrument in women's desire for a good job and a husband.

The state led economic development programs in post war Korea have been accompanied by the expansion of the middle class, which, in turn, has acted as the main agent of social and political modernization (Koo, 1999). In order to modernize, consumption became a goal for each citizen and, as Baudrillard (2008) argues, in a consumer society, the body took the role of the main vessel for it. According to Heffner, the new urban middle class is the embodiment of the ideal "modern citizenry that would realize the economic prosperity of South Korea's capitalist structural changes" (2015, p. 34) and Park Chung-hee's regime legitimized the role of the middle class in the national reconstruction (2015, p. 31). As Hogle states: "The body became a project through which self-identity was constructed, particularly, the identity as a good, productive citizen." (2005, p. 702). Pertaining to body modification, "middle-class participation in plastic surgery increased to achieve a more ''Western'' look, which from a neoliberal perspective, makes such individuals more appealing to global capital." (Heffner, 2015, p. 39). Therefore, the body becomes instrumental in two ways: as a vehicle for economic development and as a reflection of the western look. During Korea's economic boom, women's bodies, in particular, have been transformed into "consumer bodies" (Kim, 2003, p. 98). Yoon (2006) and Heffner (2015) both place women and young people at the center of the consumer society.

The 1997 financial crisis marked a turning point in Korean national identity project, where global pressures were held partially responsible for the economic decline, but at the same time, so were key characteristics of Korean identity, such as neo-Confucian morals. The West is no longer the ideal modern world, as Park notices, "we, therefore, observe the dualistic directions of national identity reformation as a specific outcome of the interplay between the strong *globalness*

and strong *localness*." (Park, 2007, p. 337). I believe this is also representative of the Korean standard of beauty, the surgically altered bodies will bear the signs of the long lasting Western influence presented previously but, also, breaking away from this influence, they create their own ideal local physical traits that will be detailed later in the new standard of beauty sought after through plastic surgery.

Key for the local view on body modification is neo-Confucianism and the view that men were destined to transcend, women were essential for their bodies as bearers of (ideally male) children (Kim, 2003, p. 100). Women are, therefore, central to the reproduction of the family, but their role is a passive one, men being the active part (Yoon, 1990, p. 10; Kim, 2003, p. 100). Furthermore, women's bodies were traditionally invisible, especially that of *yangban* members who were meant to be confined to the grounds of their household. It is with the progress of the consumer society and economic development that "women have become extraordinarily visible in Korea, free to be observed and appreciated in any public space" (Kim, 2003, p. 103). Becoming visible through modernization, the normative gaze of others and the competitive society increased the pressure to conform, at a time when they started having the means to do so thanks to the economic boom.

As indicated so far, the changes in how the body is treated, viewed, and transformed are linked to key moments in Korea's transition to modernity. Women's bodily practices in these periods are symbolic of ideas about progress, modernization, economic roles and conformity to evolving beauty standards.

RITE OF PASSAGE IN A MODERN COLLECTIVISTIC SOCIETY: AN INSTRUMENTALIST VIEW ON TRANSFORMATION

Choosing to undergo plastic surgery transforms the women into agentic subjects and help them build their personal narrative of success. The "before and after" pictures that dominate the advertisements for plastic surgery clinics and patients' testimonies can be translated into what the American culture coined as "rags to riches" or "the self-made man". It is the same promise of self-improvement, of deep transformation that women were given during Korea's economic miracle and their key role as consumers. However this agentic transformation is made, approved, and endorsed also by the collectivistic society. It is therefore not only the agency of the "I", the individual, but also the *woori*, the "we" who sanction the change and validate the conformity to the collectively shared standard of beauty.

The right to health that twentieth century marked as universal for each individual, can be taken further in Korea as "the right to beauty", the same phenomenon Edmonds (2007) revealed as characteristic for the women in Brazil, another leading country at the number of plastic surgeries per capita. Indicative of

this is the protest Korean civic groups and surgeons initiated in 2011 when the government wanted to increase 10% the tax on the five most popular plastic surgeries, claiming this "discriminated against women and the poor" (Choe, 2011). This *right to beauty* can be further translated into *the right to succeed* in life. In the discussions I had with Korean students, as well as the mass-media content analysed, the pragmatic benefit from having plastic surgery is omnipresent. Young women talked about preparing for maturity, by undergoing plastic surgery as a rite of passage. The collectivistic Korean society sanctions this practice especially through the financial help families give to young women for having their faces altered. In the TV show "Let me in" that depicts young women's and, in smaller percent, men's transformation through cosmetic surgery, the parents are supportive of the decision and sometimes take initiative, like the case of a young man being brought on the show by his parents for radical face and body surgery (Korean Makeover TV Show, 2014). The collectivistic pressures for a beautiful face are not only visible in parent – daughter interactions but also among peers. One student was eager to, during one class, to that she had had plastic surgery, even showing me her old ID card to prove it. Her colleagues and friends who were present were all supportive of her decision and acknowledged how positive the change was. She admitted that having surgery not only made her more beautiful but also more popular with her colleagues. Another girl I interviewed gave an example of a friend of hers who after undergoing surgery she became more confided and "more boys started to talk to her".

In her analysis of TV show, Joanna Elfving-Hwang claims that "Let me in" is intentionally drawing its narrative among others on filial piety, mentioning "the scenes in which parents repeatedly thank their children for their hard work, effectively reaffirming the process of cosmetic rebirth as an action that embodies filial piety through acknowledging their children's willingness to submit to physical pain as an act that erases the physical evidence of the parents' inability to ensure their children's future success." (Elfving-Hwang, 2013). As the participants of the show are mostly selected from families that cannot afford such surgeries, what Elfving-Hwang calls the "cosmetic underclass", the show seems to re-establish equality, affirming their "right to beauty" by offering contestants their much desired transformation, their success story. The participation of the parents in the transformation extends the personal fulfillment to the entire family, to the *woori* group, symbolic of a collectivistic society with strong Neo-Confucianism influences. In these conditions, for families that can afford them, paying for a child's surgery has become a usual high school present from parents. Reverting to the pragmatic economic motivation behind this practice, it appears to be socially accepted in such a large extent that Lee and Ryu (2012) choose to analyze the "return on investment" among people who had had plastic surgery. It is not important that this investment does not pay off in the end, an aspect that the authors signaled, but that it is socially considered an investment into a person's future career.

The following excerpt from a questionnaire for new patients visiting plastic surgery clinics offers an insight into the motivations to undergo these procedures. The first two alternatives confirm the practice as instrumental and as a rite of passage to maturity, while the next two indicate the conformist pressure from society and the great value Koreans place on physical appearance.

"Reason you want surgery?
[] Preparing for job
[] Wedding
[] Regaining self-confidence
[] Suggestions from people" (Marx, 2015)

The South Korea entertainment industry has produced its own versions of the American reality shows like "Extreme Makeover", "The Swan": "Let Me In", and "Miss Agent". In the testimonies of young women and men being subjected to plastic surgeries on the TV show "Let me in", the motivations and post-surgical benefits are finding a boyfriend/girlfriend, having better chances in starting a career and gaining confidence. This is in line with the show's own presentation: "A miracle, a life changing experience for women who are suffering because of their physical appearance. We aim to change lives and open doors of opportunities for women who are robbed of their confidence due to their physical appearance" (Korean Makeover TV Show, 2014). One of the participants looking to start a career has admitted the need for physical improvement due to the competitive environment: "people my age are looking for a job and I really feel that having a soft image is important for finding a job since it is so competitive these days" (Id hospital korea plastic surgery, 2014). For another participant, one of the few males on the show, the first thing he planned to do after the surgery was to find a girlfriend and go on a date, his wish being intermediated on the show, by another former contestant who arranged a blind date for him. Herself, one of the most popular participants of "Let me in", has admitted that after the surgery she has succeeded in finding a boyfriend (Korean Makeover TV Show, 2014). Like the on screen coverage of the date, another participant has received, in front of the audience, a job offer from a doctor who helped perform the surgery (Id hospital korea plastic surgery, 2013). With these two examples, the shows aim to prove the immediate fulfillment of the participants' needs through surgery, causally linking the medical technique with personal success. Achieving the transformation, the "rags to riches" dream is also exemplified on the show in the case of the young man who was evaluated by the presenters as having evolved through surgery from "country boy to celebrity" (Korean Makeover TV Show, 2014). Like Joanna Elfving-Hwang also pointed out, one of quintessential aspects of plastic surgeries is success in the consumer society. According to her, "contemporary cosmetic surgery advertising taps into the discourse of consumer identity, promising a

celebrity look that signifies success to practically anyone who can afford it." (Elfving-Hwang, 2013)

With a couple of exceptions, most of the participants taking part in "Let me in" or "Miss Agent" (a similar plastic surgery TV show) are young women in their early 20s, marking their transition to adulthood through the age corresponding landmarks (finding a job or a partner). In an in-depth article published by *the New Yorker*, the journalist found that, unless done at the right time in a person's life, he/she can become too old to undergo the transformation (Marx, 2015); another proof that this rite of passage practice is subjected to a strict temporality. This is a special feature of Korean plastic surgery phenomenon, as opposed to the West where a high percentage of surgeries are done to reduce the effects of aging.

As carriers of societal pressures in a highly visual and technologically developed environment the entertainers have helped legitimate the practice by removing the stigma associated with it, but at the same time they are also subjected to a similar surgical rite of passage. Tait's analysis on Western reality TV shows about plastic surgery shows that they "domesticate cosmetic surgery by publicising its practice, and in so doing, authorising synthetic beauty ideals. (…)The imperative to conceal surgery as a mark of inauthenticity dissipates as transformation is celebrated as self-actualisation." (Tait, 2007, p. 131). A study that analyses how media influences the demand for cosmetic surgery in South Korea, by checking related news content collected from Naver search portal news archive, from 2007 to 2013, shows "that the number of news articles about plastic surgery has increased every year, and the tone of most of the news that relates to plastic surgery has turned positive; negatively toned news is gradually disappearing" (Moon, 2005, p. 110). Although being identified as carriers of the normative beauty standards and legitimating agents, the celebrities themselves need to pass through their own rite of passage. There are accounts of record labels trying to force débutées go through surgery in order to improve their looks. In an *Elle* interview, CL, a singer in the girls' band *2NE1*, herself subject of speculation whether or not she went through surgery (Netizenbuzz, 2013) offered an account of her experience:

"YG [2NE1's record label] told me to. They told me to get plastic surgery before my debut. I stood up for myself and said "No, I'm not doing it." Like I said before, I love CL, but I still want to be Chaerin. And if I felt like I had to change I would. But I love the natural way I look. I said no and I'm not planning to." (Yi, 2013)

The plastic surgery subject has also been represented in Korean cinema, the blockbuster "200 pounds of beauty" being one of the most relevant. The star of the latter film, Kim Ah-jung, is an interesting case as she portrays a young singer aspiring to celebrity and reaching success only going through a total body make-over by means of plastic surgery; in the end, she realizes that inner beauty is what matters. In real life, the successful actress herself underwent cosmetic surgeries. To subject oneself to cosmetic surgery does not only take from the celebrities the

legitimating factor, but also standard. Looking like a celebrity becomes the ideal, the norm. The contestants of “Let me in” and „Miss agent” are often evaluated and praised for the surgeries results with exclamations like “as beautiful as a celebrity”, “just like a star”, „more beautiful than a star”. One girl I interviewed confirmed the influence of celebrities by the fact that “several years ago, when somebody wanted a surgery but didn’t know anything, they were bringing pictures of celebrities and asked the doctors to make them look like that”.

In the domestication process of plastic surgeries, a key role is reserved for the surgeons, who are, as celebrities, carriers of the social pressures put on young women’s bodies but with a further legitimating advantage: that of a medical expert. The doctors are regular active participants on the cosmetic surgeries TV shows and their role is to medically present the transformation. The experts are becoming celebrities themselves and medical jargon is popularized and integrated into everyday life discourse about beauty. The surgeons’ presentation of the medical interventions abounds with detailed medical vocabulary but, at the same time, their jargon borrows popularized expressions, for example, all interventions pertaining to jaw line are commonly referred to as “V-line surgery”. Moreover, the celebrity expert will not remain confined to medical analysis but, in assessing the surgeries results on participants, the surgeon will proceed to also evaluate the post-surgery beauty: “For a more masculine appeal, a straighter crease line was created for a sassy celebrity-like look” (Korean Makeover TV Show, 2014).

The last scene from the movie „200 pounds of beauty” is suggestive of the normative function plastic surgeons play. The surgeon introduces himself to a potential patient as follows: “I am the famous doctor Lee, also known as “the hands of God”. I could even win the next Nobel Prize. What do you want me to fix?” Using the term to fix already suggests the abnormality of not falling into the standard of beauty, and describing himself “the hands of God” he is meant to surgically restoring the new accepted standard of normality.

The role of the plastic surgeons in consolidating the popularly shared standards of beauty and, with their participation in TV shows, further popularizing the medical jargon is reminiscent of Kaw’s criticisms, in Foucault’s and Gramsci’s tradition, of the role the “expert” knowledge has, through plastic surgeons in this case, in defining common sense reality (Kaw, 1993, p. 78).

INNOCENT GLAMOUR – THE TRULY KOREAN BEAUTIFUL BODY

A small face, pointy chin, high nose, visible forehead, under eye bags also known as “love bands”, and fair skin depict the Korean beauty standard. Briefly put, it is an innocent, non-sexual, “V-line”, “Baby face” look. This facial ideal shares the big eye, high nose and white skin with the Caucasian physical traits (with the exception of the alternative tanned skin popular in Western countries).

Besides the historical factors I presented so far, some researchers find as cause for this westernization of features the fact that Korean advertising industry used Caucasian models since 1994 when it was legally permitted (Kim in Holliday and Elfving-Hwang, 2012:67).

“The imbalance in model ethnicity in both U.S. and Korean magazines was particularly interesting, with Caucasian models being used predominantly in both countries. The majority of models represented in the ads in Korea, including the publications of Korean origin, were Caucasian, which indicated the heavy Western influence there.” (Jung and Lee, 2009:283)

However, present day Koreans are not simply mimicking Caucasian features; if we look at the facial criteria for a beautiful face, there are several local traits. The “love bands” or under eye bags are considered a flaw for western women and the plastic surgery Koreans go through to enhance them is called "Youthlites" which is suggestive of the young, innocent look it aims to reproduce. The pointy chin is also an indigenously idealized feature and one that is represented in the “V-line” ideal. Furthermore, the most popular plastic surgeries in Korea are those aiming to modify the face, whereas in the Western countries, breast enhancement is among the most sought after practices. This, as well, is in line with the non-sexual look Korean women try to attain. There was a general consensus among the Korean women and men I talked to while living in Korea that showing cleavage was not considered socially acceptable even when compared to, for example, very short skirts, or pants. The main reason for this was that it creates a too sexual image compared to the Korean beauty standard.

A user’s comment on an online forum is representative of Koreans’ rejection of the claim that they are merely importing Caucasian features: “There is something you don't get. Asians don't do plastic surgery to look white. They do plastic surgery to look wide-eyed-Asians. But they don't do it to look white. Just check their standards. They're so different from white people’s” (Guest, 2014). From my findings, in the interviews, the informal discussions, or blog posts, Koreans reject the claim that the change was done towards a Caucasian ideal and, sometimes, take offence in the question. I have not yet found a Korean admitting to having had surgery to look Western, but that they do to look beautiful, even if that entails some traits are shared with Caucasian features. Holliday and Elfving-Hwang claim that this blend of Korean beauty image is more than just westernization, but a more “globalized image, embodying idealized elements from many different cultures” (2012, p. 58).

The success of the Korean beauty standard in being replicated through plastic surgery is not only due to its popular standard mixing both universal and culturally specific features but also due to its singularity and this we can link to the social context and social pressures. The centripetal force of the collectivistic society, where people shouldn’t stand out has taken its toll on the standards of beauty leading to an almost singular ideal face. As Wegenstein and Ruck show, this is

characteristic of the culture industry that "propagates only limited models of beauty to conform to or, as Egginton (2009, p. 188) puts it: 'what is unlimited by technology, however, is finally limited by the models and templates society provides'" (2011, p. 50).

To sum up, the ideal body image Korean women embrace is that of an innocent, non-sexual, soft and delicate beauty, often associated, as noticed in the plastic surgery reality shows, with doll or Barbie like appearances. This standard goes around under different names ranging from "Bagel girl" (a girl with a glamourous body and a baby face), "innocent glamour", or "baby face". The roots of how this standard was built appear to be irrelevant for young women and the claim of one of the presenters on the reality show "Miss Agent" that "the small and delicate face already became the world beauty standard" is highly suggestive of its normative force (Id hospital Korea plastic surgery, 2013). Transforming their face to look more Western doesn't appear to be any longer a theme in the discourse about surgery, moreover the standard appears to spread its normative force even outside its borders.

An aspect of this research which must be highlighted is the correlative assumptions that there is a societal expectation that women must be attractive and that women subject themselves to societal roles and assumptions more frequently than men. In my conversations with students and the interviews I took there was an almost overwhelming agreement that women need to be more preoccupied with their bodies. As one girl I interviewed admitted: "of course girls are having more [surgeries] because for boys this aspect is not that important, but for girls it is important how they look. I mean boys need to be smear and girls need to be beautiful and pretty. I think this is how our society is now".

This rigid normative standard in the context of a collectivistic, highly conformist society has a troubling potential. Due to the large percentage of people who undergo plastic surgery, the common people (those not having such surgery) are no longer perceived as common, but rather as abnormal.

CONCLUSION

The earliest encounter with Western bodies, the colonial period, the Korean War, the economic boom, and to present day Korea, I showed how women's views of their bodies and social context has led to the surge in plastic surgeries and how they are altering their faces to meet a locally created blend of facial features that combines both Western influences, and indigenous specificities. The "Baby face", "Innocent Glamour" standard is suggestive of the innocent look they intend to reproduce that differs from the stereotypical sexual image of Western women they want to depart from. Furthermore, I conclude that Koreans modify their bodies, not to look more Caucasian, but to conform to the highly rigid beauty standard that has

emerged in this collectivistic society, a standard that has already been interiorized as genuinely Korean by young women and which begins to assert itself as such even across borders, especially in the Asian space. It is perhaps such developments that come to show the successful modernization project of Korea that, in this respect, transformed itself from a country where the local body was normalized towards the foreign Western standard, if we think of the work of doctor Millard, into a country that is starting to impose its ideal to other nations.

The body going through surgery is also instrumental to young women's success in life. While choosing this practice, they show agency; it is a sign of self-realization. The moments they go through these bodily modification techniques are key points in their lives: before starting a career or finding a husband. Plastic surgery, therefore, has the role of a rite of passage; it is a moment of the self in transition and a promise of success. It also became an expression of a *right to beauty* and consequently a *right to success*; for those going through plastic surgery it is a key aspect in creating their personal narrative of transformation.

However, besides being symbolic of the affirmation of the self, plastic surgeries are also representative of how women conform to the social pressures of a collectivistic society. They are supported and even advised by their parents to alter their bodies (e.g. receiving the surgery as a gift for graduation) to increase their chances of success that is consequently extended to the family as part of the collectivistic dynamic. As previously shown, the conformist pressures also came from celebrities who helped legitimize these medical practices. Looking like a celebrity becomes an epitome of Korean standard of beauty although the actors in the entertainment industry are themselves subjected to the same dynamic, in which the pressure to conform and to succeed makes surgeries a rite of passage from the debutant status to a successful entertainer. Besides the celebrities, surgeons are also carriers of the social pressures to standardize and normalize the body, their influence being made from the vantage point of their medical and expert superiority.

REFERENCES

200 Pounds Beauty. (2006) Film. Directed by Kim, Y. H. [DVD]Seoul: K.M. Culture Co.

BAUDRILLARD, J. (2008) *Societatea de consum. Mituri şi structuri*. Traducere Alexandru Materi. Bucuresti: Comunicare. Ro.

BRETON, D. (2002) *Antropologia corpului şi modernitatea*. Traducere DoinaLică. Timişoara: Amarcord.

BUDGEON, S. (2003) Identity as an Embodied Event. *Body & Society*. 9 (1). p. 35–55.

CHOE, S. H. (2011) In South Korea, Plastic Surgery Comes Out of the Closet. *The New York Times*. [Online] 3rd November. Available from: http://www.nytimes.com/2011/11/04/world/asia/in-south-korea-plastic-surgery-comes-out-of-the-closet.html [Accessed: 10th May 2015].

CORBIN, A., COURTINE, J.-J. AND VIGARELLO, G. (2008) *Istoria corpului. Mutatiile privirii: secolul XX, vol III.* Traducere Simona Manolache, Mihaela Arnat, Muguraş Constantinescu, Giuliano Sfichi. Bucureşti: Art.

DAVIS, K. (2003) *Dubious equalities and embodied difference. Cultural studies on cosmetic surgery*. Lanham: Rowan and Littlefield Publishers

EDMONDS, A. (2007) The poor have the right to be beautiful: cosmetic surgery in neoliberal Brazil. *Journal of the Royal Anthropological Institute.* 13 (2). p. 363–381.

ELFVING-HWANG, J. (2013) Cosmetic Surgery and Embodying the Moral Self in South Korean Popular Makeover Culture. *The Asia-Pacific Journal*. 11 (24/2). p. 1–11.

FEATHERSTONE, M. (2010) Body, Image and Affect in Consumer Culture. *Body & Society*. 16 (1). p. 193-221.

GILMAN, S. (1999). *Making the Body Beautiful: A Cultural History of Aesthetic Surgery*.

Princeton, NJ: Princeton Univ. Press.

GUEST. (2014) comment added 17th November on Netizenbuzz. *Plastic surgery on the rise after the end of college entrance exams*. [Online] Available from: http://netizenbuzz.blogspot.ro/2014/12/plastic-surgery-on-rise-after-end-of.html. [Accessed: 19th April 2015].

HAIKEN, E. (1997) *Venus Envy: A History of Cosmetic Surgery*. Baltimore: Johns Hopkins University Press.

HEFFNER, H. (2015) "A Dragon Risen from a Shallow Stream": The South Korean Middle Class Framed Through Narratives of Loss, Progress, and Return. *Alternatives: Global, Local, Political*. 40(1). p. 31–45.

HEYES, C.J. (2007) Normalisation and the psychic life of cosmetic surgery. *Australian Feminist Studies*. 22 (52). p. 55–71.

HOGLE, L.F. (2005) Enhancement technologies and the Body. *Annual Review of Anthropology*. 34. p. 695–716.

HOLLIDAY, R., ELFVING-HWANG, J. (2012) Gender, Globalization and Aesthetic Surgery in South Korea. *Body & Society*, 18 (2). p. 58–81.

ID HOSPITAL KOREA PLASTIC SURGERY (2013)*[cosmetic surgery korea review] facial contouring surgery, amazing makeover!*. [Online] https://www.youtube.com/watch?v=kVdtHHBMbCo&index=6&list=PLeZD3wSpSMdrQBOZgeUhlYv9meG2c6gOP. [Accessed: 20th July 2015].

ID HOSPITAL KOREA PLASTIC SURGERY (2014)*Underbite Jaw Surgery - before & after (Oral and maxillofacial surgery)*. [Online] Available at: https://www.youtube.com/watch?v=QFF4jBBJh24&index=4&list=PLeZD3wSpSMdrQBOZgeUhlYv9meG2c6gOP. [Accessed: 19th July 2015].

JUNG, J., LEE, S.H. (2006) Cross-Cultural Comparisons of Appearance Self-Schema, Body Image, Self-Esteem, and Dieting Behavior Between Korean and U.S. Women. *Family and Consumer Sciences Research Journal*. 34 (4). p. 350–365.

JUNG, J., LEE, Y. J. (2009) Cross-Cultural Examination of Women's Fashion and Beauty Magazine Advertisements in the United States and South Korea. C*lothing and Textiles Research Journal*. 27 (4). p. 274–286.

KAW, E. (1993) Medicalization of Racial Features: Asian American Women and Cosmetic Surgery. *Medical Anthropological Quarterly*. 7 (1). p. 74–89.

KOREAN MAKEOVER TV SHOW (2014) *(men)let me in korean tv show eng sub*. [Online] Available at: https://www.youtube.com/watch?v=Gd-bISK3lkc. [Accessed: 19th July 2015].

KIM, N.Y (2008) *Imperial Citizens: Koreans and Race from Seoul to LA*. Stanford, Calif: Stanford University Press.

KIM, T. (2003) Neo-Confucian Body Techniques: Women's Bodies in Korea's Consumer Society. *Body & Society*. 9 (2). p. 97–113.

KOO, H. (1999) Modernity in South Korea: An Alternative Narrative. *Thesis Eleven*. 57. p. 43–64.

KOO, K.S. (2004) The Body Beautiful: Symbolism and Agency in the Social World. *Annual Review of Anthropology*. 33. p. 297–317.

LEE, S. and Ryu, K. (2012) Plastic Surgery: Investment in Human Capital or Consumption?. *Journal of Human Capital.* 6 (3). p. 224–250.

MARX, P. (2015) About Face. *The New Yorker*. [Online] 26th March. Available from http://www.newyorker.com/magazine/2015/03/23/about-face. [Accessed: 22nd May 2015].

MOON, M. (2015) Cosmetic surgery as a commodity for 'sale' in online news. *Asian Journal of Communication*. 25 (1). p. 102–113.

NEGRIN, N. (2002) Cosmetic Surgery and the Eclipse of Identity. *Body & Society*. 8 (4). p. 21–42.

NETIZENBUZZ. (2013) *CL reveals she got plastic surgery offers before her debut*. [Online]Available from: http://netizenbuzz.blogspot.ro/2013/03/cl-reveals-she-got-plastic-surgery.htm. [Accessed: 19th May 2015].

SCHOUTEN, J.W. (1991) Selves in Transition: Symbolic Consumption in Personal Rites of Passage and Identity Reconstruction. *Journal of Consumer Research*. 17 (4). p. 412-425.

SOUTH KOREA. SeoulTouchUp. (2014) *Korean Plastic Surgery Statistics*. [Online] Available from: https://www.seoultouchup.com/korean-plastic-surgery-statistics/ [Accessed: 10th April 2015].

PARK, G.-S., Y.S. Jang, and H.Y. Lee (2007) The Interplay between Globalness and Localness: Korea's Globalization Revisited. *International Journal of Comparative Sociology*. 48. p. 337–353.

TAIT, S. (2007) Television And The Domestication Of Cosmetic Surgery. *Feminist Media Studies*. 7 (2). p. 119–135.

THE INTERNATIONAL SOCIETY OF AESTHETIC PLASTIC SURGEONS. (2013)*ISAPS International Survey on Aesthetic/Cosmetic. Procedures Performed in 2013.* [Online] Available from: http://www.isaps.org/Media/Default/global-statistics/2014%20ISAPS%20Global%20Stat%20Results.pdf. [Accessed: 15th April 2015].

THE INTERNATIONAL SOCIETY OF AESTHETIC PLASTIC SURGEONS. (2016)*ISAPS International Survey on Aesthetic/Cosmetic. Procedures Performed in 2015.* [Online] Available from: https://www.isaps.org/Media/Default/global-statistics/2016%20ISAPS%20Results.pdf. [Accessed: 13th March 2017].

WEGENSTEIN, B., RUCK, N. (2011) Physiognomy, Reality Television and the Cosmetic Gaze. *Body & Society*. 17 (4). p. 27–54.

YI, D. (2013) Meet Jeremy Scott's muse: K-Pop star CL. *Elle*. [Online]21st March. Available from: http://www.elle.com/culture/celebrities/news/a15248/cl-2ne1-jeremy-scott-muse/. [Accessed: 10th May 2012].

YOO, S.Y. (2001) Embodiment of American modernity in colonial Korea. *Inter-Asia Cultural Studies*. 2 (3). p. 423-441.

YOON, K. (2006) The making of neo-Confucian cyberkids: representations of young mobile phone users in South Korea. *New Media & Society*. 8 (5). p. 753–771.

PRIVACY CONCERNS ON THE INTERNET: INVESTIGATING THE ATTITUDES AND BEHAVIOURS OF YOUNG INTERNET USERS TO ONLINE ANONYMITY

CHIKEZIE EMMANUEL UZUEGBUNAM [*]
HENRY CHIGOZIE DURU[**]

ABSTRACT

Privacy on the Internet is a multi-faceted issue that requires attention on the user's part, both to protect information from third-party data collection and to manage personal impressions across a variety of contexts and relationships (Ellison, *et al*, 2011). This study investigated the notion of online anonymity, as a privacy issue, among young Internet users in Nigeria. Situated within the framework of the deindividuation, uses and gratifications, and technological determinism theories, the research was designed as a survey. A sample of 400 respondents was selected from the study population (which was the undergraduate students of Nnamdi Azikiwe University, Awka, Anambra State, in South-East Nigeria) and a structured questionnaire employed as the data collection instrument. Findings showed that online anonymity is common among a significant part of the users; and that they utilise online anonymity mainly for the purposes of protecting their privacy, shielding themselves against fraud and other Internet harms and abuses, and for fun. Similarly, it was found that while the youths perceive online anonymity as socially beneficial, they at the same time view it as potentially destructive. The study also discovered that anonymity has not had significant impact on the Internet use habit of the respondents. This means that it is not a motivating factor that draws them to the Internet, and that it has neither made them feel free to communicate nor lured majority of them towards communications that are ethically and legally undesirable.

Keywords: *Anonymity, privacy, young Internet users, social network sites, uses-and-gratifications theory.*

---

[*] Lecturer, Nnamdi Azikiwe University, Awka – Nigeria, PhD Scholar, University of Cape Town, South Africa. E-mail: chikezieuzuegbunam@gmail.com; ce.uzuegbunam@unizik.edu.ng.

[**] Doctoral Student/Independent Researcher, Nnamdi Azikiwe University, Awka, Nigeria. E-mail: duru_henry_chigozie@yahoo.com

Rom. Jour. of Sociological Studies, New Series, No. 1, p. 89–105, Bucharest, 2017

(cc) BY-ND
Creative Commons License
Attribution–NoDerives CC-BY-ND 4.0

BACKGROUND OF THE STUDY

The use of the Internet is increasingly becoming a marked feature of today's communication culture the world over. In Nigeria, this trend is no less visible, especially considering the impressive statistics of Internet access and use. The country has an estimated 28% for Internet penetration in Africa, followed by Egypt (10%), making her top in Internet population in Africa. In world ranking, Nigeria has ranked 7th in the top 20 countries with the highest number of Internet users, after China, India, United States, Brazil, Japan and Russia (*Internet World Stats,* 2016). All this is testament of the vibrant Internet culture already existing and growing in the country.

While this trend is definitely a positive one given that Internet access and use has become a fundamental element of social empowerment in the contemporary world, there might still be some causes for worry considering the perceived potential danger equally posed by the Internet. Amongst the features of the Internet that has given rise to this sentiment is anonymity—a feature that enables online users to effectively conceal their identities either by communicating anonymously or by using the pseudonyms (Palme & Berglund, 2007). Though the Internet's amenability to anonymous use has been seen, in a number of respects, as advantageous – particularly in the area of enhancing free speech (Davenport, 2012; Nwagwu, 2007) – the potential social hazard of this feature has not also been lost on scholars and other stakeholders (Dreyfus, 1998; Armstrong & Forde, 2003; Longe *et al.*, 2007; Adeniran, 2008; Mayer, 2009; and Davenport, 2012). Armstrong & Forde (2003, p.3) summarises this fear:

> Money laundering, drug dealing, terrorism, hacking, fraud, child pornography and the distribution of objectionable material are crimes that are perpetrated using the Internet. Criminals utilise software tools and valuable knowledge from the Internet as well as embracing the Internet's global communications system to participate in virtual communities of disguised people. The Internet provides the facilities for people with criminal intent to associate and exchange intelligence with reduced risk to their personal identification.

Admittedly, the fact that the Internet is amenable to anonymity would not necessarily mean that users would always explore this feature, and the fact that users explore this feature would not necessarily mean that they do this negatively. In other words, the possibility that online anonymity would have negative impact on the society would be dependent on how much people utilise online anonymity and how they utilise it. Secondly, whether and how they utilise it could be greatly influenced by their perception (i.e. judgment and attitude) towards it. Against this backdrop, this study proceeded to investigate the notion of online anonymity among young Internet users in Nigeria.

THE RESEARCH PROBLEM

The Internet's amenability to anonymous use has been hailed as beneficial in certain respects (Davenport, 2012; Nwagwu, 2007), however, its social risks in terms of exposing the society to possible value crisis and insecurity have equally been documented (Dreyfus, 1998; Armstrong & Forde, 2003; Longe *et al*., 2007; Adeniran, 2008; Mayer, 2009; and Davenport, 2012). Thus, Tardanico (2012) posits that the Internet technology and the anonymity it affords make it possible for anyone to hide behind any social network to post or project any image they fancy, and thus creates a fantasy they will. This possibility could create a range of undesirable developments including thriving of social ills such as fraud, pornography, drug abuse, etc, in the society (Longe *et al.,* 2007; Adeniran, 2008). As observed by Orson Scott (2008, p.16); "With false names, on the right nets, there could be anyone, as long as they are careful about the way they wrote. All that anyone could see were words, their ideas." This dilemma arguably becomes a cause for worry, particularly in the light of the increasing use of the Internet in today's communication culture, most visibly among the young populations.

Added to this concern is the fact that majority of the Internet users in Nigeria are young persons (Amaefule, 2012; Uzuegbunam, 2015), with many of them obviously teenagers and young adults who are naturally very adventurous and often overly excited by technology.

PURPOSE OF THE STUDY

The general purpose of this study was to understand the attitudes and behaviors of young Internet users towards online anonymity and the reason behind the anonymous identities they took on the Internet.

Research Questions

To meet the above objectives, the following research questions were pursued:

1. To what extent do young Internet users utilise online anonymity?
2. How do these users perceive anonymity on the Internet?
3. What are these users' motivations for anonymous identities on the Internet or the attraction the online anonymity holds for them?
4. What are the effects of online anonymity on these users?

Significance of the Study

Many studies have focused on the Internet use habit of young Nigerians; these efforts appear to have left out an aspect of this habit, which is anonymity.

Apparently, they have failed to investigate the occurrence and role of this phenomenon as a component of Internet use habit among this population. Filling this gap constitutes the significance of this study. This research may be relevant to the work of media educators as they endeavor to develop media literacy of the people, especially young users. Through the insight they might gain from the results of this study, they could be in a better position to impart in their trainees the relevant media literacy as it relates specifically to anonymity and privacy on the Internet. The research also enriches scholarship, especially in the aspect of new media and its usage culture. More specifically, the study throws light on the culture of online anonymity, the nature of its utilisation among young users and likely effects of such. Generally, the study adds relevant information to the existing literature as well as generates data for scholarly reference.

LITERATURE REVIEW

In the words of Palme & Berglund (2007, p.11), anonymity "means that the real author of a message is not shown. Anonymity can be implemented to make it possible or very difficult to find out the real author of a message." A common variant of anonymity is pseudonymity, where another name than the real author is shown. The pseudonym is sometimes kept secret; sometimes the real name behind a pseudonym is openly known (Palm & Berglund, 2007).

According to Mayer (2009, p.16), there are two general properties of anonymity on the Internet:

- A service or user cannot gain significant knowledge about another user's identity from the actions they take;
- A service or user cannot determine whether a set of actions were committed by the same user or group of users.

An advantage of a pseudonym, compared with complete anonymity, is that it is possible to recognise that different messages are written by the same author. It is possible to have long discourse between two persons using pseudonyms with none of them knowing the real name behind the other's pseudonym. However, a disadvantage for a person who wants to be anonymous is that combining information from many messages of the same person may make it easier to find out who is the real person behind the pseudonym (Mayer, 2009).

The construct of anonymity has long been of interest to social psychologists and other social scientists (Christopherson, 2007). Anonymity has traditionally been conceived as the inability of others to identify an individual or for others to identify one's self. This may be within a large social context, such as a crowd, or in smaller context, such as two-person communications on the Internet (Christopherson, 2007).

However, it has been suggested that there are really two broad categories of anonymity; technical anonymity and social anonymity (Hayne & Rice, 1997). Technical anonymity refers to the removal of all meaningful identifying information about others in the exchange of material. This can include the removal of one's name or other identifying information from Internet communications. Social anonymity refers to the perception of others and/or one's self as unidentifiable because of the lack of cues to use to attribute an identity to a certain individual. In other words, it may not be the case that one is truly anonymous in a social context, but the individual perceives himself or herself to be anonymous to others. Both categories of anonymity have traditionally been investigated by social science researchers (Christopherson, 2007; Hayne & Rice, 1997).

Online anonymity has been viewed as advantageous in some sense, particularly as related to freedom of expression and growth of democratic culture. Citing American Association for the Advancement of Science, Davenport (2012, p. 33) states this school of thought:

> Anonymous communication is seen as the cornerstone of an Internet culture that promotes sharing and free speech and is overtly anti-establishment. Anonymity, so the argument goes, ensures governments cannot spy on citizens and thus guarantees privacy and free speech. The recommendations of the American Association for the Advancement of Science's conference on "Anonymous Communication Policies for the Internet" support this view. Among the findings were that "online anonymous communication is morally neutral" and that "it should be considered a strong human and constitutional right…"

However, critics of online anonymity have continued to point out its potential risks for the society. Notable among these risks are Internet fraud and pornography. Thus, Longe *et al.* (2007, p.195) argue that "The Internet, aided by technology-induced anonymity has popularized the sex business more than any other means of advertisement." Similarly, Mayer (2009, p.9) contends that despite "its popular veneration, anonymity is not without its flaws; by rendering accountability impossible, anonymity enables libellous or criminal activity without fear of retribution."

Equally commenting on the dangers posed by Internet anonymity, Adeniran (2008, p.369) says:

> The anonymity and privacy that the Internet provides to potential users has excessively enhanced the degree of fluidity and structural complexity of the yahooboys' operations in Nigeria. Today, they get access to the Internet without exiting the home. Embezzlements, electronic frauds, fictitious sales of properties and cars are all being carried out without leaving a trace.

Arguing against the notion that anonymity is fundamental to free speech which is at the heart of democracy, Davenport (2012, p.35) contends that "Accountability lies at the very heart of the democratic tradition and is crucial to

the continued stability of a free and fair society." Without accountability, there is little or no trust which is the key to securing effectiveness of communication. Davenport (2012, p.34) writes further:

> Besides, messages sent anonymously are unlikely to have much impact on their own. Only if the recipient of a message knows and trusts its writer is action likely to ensue. Trust is built up as a result of numerous encounters, but if the communications are truly anonymous then it is difficult to establish such a relationship. Messages sent anonymously are thus unlikely to have much impact on their own and hence reliance on anonymous communications for whistle-blowing, informing the world of human rights violations, or promulgating a political platform would seem to be misplaced.

Experience suggests that a society relying solely on the goodwill and conscience of its citizens would unlikely succeed in ensuring law and order. Similarly, attempting to guarantee law and order by adopting measures preventing the very possibility of wrongdoing is unfeasible since there is little hope of covering all eventualities (Longe *et al.* 2007; Adeniran, 2008; Davenport, 2012). Hence, Internet anonymity would remain a source of dilemma for societies as they try to balance free speech and public order.

Many studies have focused on the patterns of use of the Internet among youths in Nigeria. Findings have generally shown that Internet access is widespread among this category of population (Ojokoh & Asaolu, 2005; Mishra, 2009; Bankole & Babalola, 2012; Fasae & Aladeniyi, 2012; Ekweli, 2014; Uzuegbunam, 2015). Statistics from these studies, when read together with those from other sources such as the International Telecommunications Union (ITU, 2004) and Internet World Stat (Amaefule, 2012), strongly suggest that most of Internet penetration in the country has concentrated on this young population.

Internet platforms which youths in Nigeria have been found to use mostly include search engines (Mishra, 2009; Bankole and Babalola, 2012; Ekweli, 2014); E-mails (Bankole and Babalola, 2012; Ekweli, 2014); and social networking sites (Bankole and Babalola, 2012; Uzuegbunam, 2015). These three—E-mails, search engines and social networking sites—featured consistently as the most prominently accessed Internet services among the students.

Literature has shown that young people in Nigeria have used the Internet for information and knowledge seeking; in fact, they have adjudged the Internet as more viable than older sources of information and knowledge (Jagboro, 2003; Awoleye, Siyanbola, Oladipo, 2008; Mishra, 2009; Kayode-Edebor, 2011; Fasae and Aladeniyi, 2012). Furthermore, Mishra (2009), Anasi (2006) and Udende (2010) have discovered that this pattern of use have had real positive impact on the academic life of students. But, in addition to this, Awoleye, Siyanbola & Oladipo

(2008) have also found that the Internet have positively impacted the social life of the students. Apart from information and knowledge-seeking purposes, young users have—to a significant extent— utilised the Internet for the purpose of networking, interaction and leisure (Jagboro, 2003; Awoleye, Siyanbola, Oladipo, 2008; Mishra, 2009, Fasae & Aladeniyi, 2012; Ekweli, 2014).

However, while a plethora of studies have focused on the Internet use habit of young Nigerians, these efforts appear to have left out an aspect of this habit, which is anonymity. These studies may have failed to investigate the occurrence and role of this phenomenon as a component of Internet use habit among this age group. This constitutes the gap which this study intended to address.

THEORETICAL FRAMEWORK

One of the most influential theories describing the effect of anonymity on behavior is deindividuation theory propounded by Zimbardo in 1969. The deindividuation state was described as a state in which individuals within a group are not "seen or paid attention to as individuals" (Christopherson, 2007).

Thus, under the anonymity provided by being a member of a crowd, it was predicted that when "under conditions where the member is not individuated in the group, there is likely to occur for the member a reduction of inner restraints against doing various things" (Festinger *et al.*, 1952, p. 382).According to Postmes (2001), "deindividuation is a characteristic of the individual in the crowd. It is a psychological state of decreased self-evaluation, causing anti-normative and disinhibited behavior." Deindividuation theory is rooted in some of the earliest social psychological theorizing, more than a century ago. It seeks to explain the apparent transformation of rational individuals into an unruly group or crowd. It posits that the group provides "an environment in which the individual— submerged and anonymous – suffers from a loss of self-awareness. Deindividuation hinders reflection about the consequences of actions, rendering social norms impotent while increasing suggestibility to random outside influences" (Christopherson, 2007, p.13).

The deindividuation theory would help to conceptualise the tendency of individual Internet users to act "irresponsibly" while they remain anonymous on the Internet. An anonymous individual might feel him/herself "lost" in the crowd of multitude who exist in the cyberspace; his/her sense of individual responsibility could be lost, thus the user could be lured into doing acts he/she could not have done were his/her identity known. Citing Saldarini & DeRobertis (2003), Longe & Longe (2005, p.61) summarise this position thus:

> The impact of a technologically induced feeling of anonymity has generated a "new self"; one that will continue to expand in the 21st

> century. An online-self that exists in the arena of the cyberspace has been unleashed with a potential to behave in a way that is ethically suspect. They noted sex offenders find the anonymity of online interactions to be the Internet's most attractive feature.

The uses and gratifications theory is also relevant to the subject of investigation here. This theory postulates that the nature and extent of the effect of the mass media on the audience is conditioned by the uses which the audiences make of the media. The bottom line of uses and gratification theory is that media do not do things to people; rather, people do things with media (Ojobor, 2002). Specifically, according to Burgeon, Hunsaker & Dawson (1994, pp.374-375), the objective of uses and gratification theory is to explain how individuals use mass communication to gratify their needs.

The uses and gratifications theory also highlights the positive consequences of individual media use. In their contribution, Baran and Davis (2001) conclude that audience members actively seek out the mass media to satisfy individual needs. These include learning, passing time, companionship, escape from tension, excitement and relaxation.

In the context of this study, therefore, the uses and gratifications theory helps to view the young Internet user in Nigeria as an active user that seeks to satisfy certain personal gratifications in accessing the Internet. It is such gratifications that would determine his/her decision to be or not to be anonymous online as well as his/her behaviour under such anonymity.

Also relevant here is the theory of technological determinism which affirms that technology is at the root of all social phenomena including development. It is a reductionist theory which believes that humans are conditioned by technological advancements as they actualise their existence; that their actions are inevitably shaped by the nature and the extent of technological structures existing in the society at any point in time (Leonard, 2008; Baran and Davis, 2001). In other words, we are without choice and freewill as far as technology is concerned. Thus, the technological determinism perspective will view online anonymity as a creation of technology. That is, according to this theory, Internet users cannot but be anonymous; they are compelled to be anonymous according to the determination of the technology known as Internet.

METHODOLOGY

This research was designed as a survey. In the researchers' view, this study, being an investigation of uses, perception and effect of online anonymity on a particular population, would best achieve its objectives through surveying the concerned population.

The area of study was Nnamdi Azikiwe University, Awka, Anambra State, in South-East Nigeria. This is a federal government's higher education institution with 14 faculties. The population of this study was the undergraduate students of Nnamdi Azikiwe University. They number about 34,650 according to the information sourced from the university registry in 2015. Using Taro Yamane's formula for sample size determination we arrived at a sample size of 399 (approximated to 400). The sampling procedure was multi-stage in approach. The researchers conducted their sampling in three stages: selection of four faculties; two departments from each of the four faculties; fifty students randomly selected from each of the total eight departments earlier selected. The questionnaire consisted of twenty close-ended, structured questions. The instrument was pre-tested via a pilot study. Its validity and reliability were established in this way.

Data Presentation and Analyses

Of the 400 copies of the questionnaire distributed, 393 were recovered, representing 98.3%, while 7 were not recovered, representing 1.7%. Thus, the response rate was 98.3%. Demographically,while 66.3% of the respondents were males, 33.7% were females. The figures indicate that the number of males was almost twice that of females–the difference between the two being as wide as 32.6%. This situation occurred for the reason that, at the last stage of the sampling procedure, the researchers selected their respondents at random without seeking to balance the sexes. Furthermore, the respondents were between 15 and 19 years; 67.3% were between 20 and 24, 14% were between 25 and 29, while 6.1% were 30 and above. These data imply that majority of the respondents were between 15 and 19 years; collective only 32.7% of the respondents fell out of this age bracket.

Patterns of Internet Use

Data collected show that all of the respondents said they use the Internet. In other words, there is 100% Internet use among the respondents. This, however, does not necessarily imply that all of the respondents are personally connected to the Internet.

Table 1

Respondents' Major Purpose of Internet Use

	Frequency	Percentage
News/Information	96	24.4%
Academic Research	56	14.2%
Social Networking	91	23.2%
Entertainment	91	23.2%
Others	49	12.5%
Not Certain	10	2.5%
TOTAL	393	100%

The above-table shows that 24.4% of the respondents used the Internet mainly for news/information; 14.2% use it mainly for academic research; while 23.2% use it principally for social networking. Similarly, 23.4% use the Net mainly for entertainment; 12.5% use it for other purposes; while 2.5% were uncertain as to their major aim of use. These data show that news/information ranked highest, though with a very slight margin over social networking and entertainment as the main gratification which the respondents seek to satisfy via the Internet. The fact that the respondents were all young people could help to explain the prominence of social networking and entertainment here.

Patterns of Use of Online Anonymity

Table 2

Hiding of Identity or Use of Pseudonym on Online Account
(Facebook, Twitter, YouTube, etc) by Respondents

	Frequency	Percentage
Yes	242	61.6%
No	151	38.4%
TOTAL	393	100%

The table 2 shows that 61.6% of the respondents have any online account (such as Facebook, Twitter, YouTube etc) which hides their true identity because it bears neither their real name nor photograph; while 38.4% do not own such. The implication of this is that slightly more than 60% of the respondents have at least one online account that does not show their identity by way of either name or photograph.

Table 3

Hiding of Identity while Making Posts Online

	Frequency	Percentage
Yes	298	63.4%
No	144	36.6%
TOTAL	393	100%

The above-table shows that 63.4% of the respondents have hidden their identity while making any post online by not using their real name or photograph; while 36.6% have not. This is different from the data in previous table which concern online accounts only. Table 3 concerns all posts made online whether through one's account (Facebook, Twitter, YouTube, etc) or through any other platform. The data in this table indicate that about three-quarter of the respondents have not made such anonymous posts.

The table 4 shows that none (0%) of the respondents always hide their identity while making any post online; 23.2% do this sometimes; 1% hide theirs rarely; while 75.8% gave no answer – probably because they had earlier indicated that they have not in this way hidden their identity. However, when the number who gave no answer is eliminated, then 95.8% hide their identity sometimes; while 4.2% hide theirs rarely.

Table 4

Frequency of Hiding of Identity Online

	Frequency	Percentage
Always	0	0%
Sometimes	91	23.2%
Rarely	4	1%
No answer	298	75.8%
TOTAL	393	100%

Purposes of Use of Online Anonymity

Table 5

Purposes of Online Anonymity

	I hide my identity on the Internet for fear of getting into trouble about what I post?	I hide my identity on the Internet for fear of Internet fraudsters and other online harmers?	I hide my identity on the Internet for fear that my contribution might not impress others all the time?	I hide my identity on the Internet to preserve my privacy?	I hide my identity on the Internet because I am reluctant to associate?	I hide my identity on the Internet just for the fun of it?
True	7.6% N = 30	17.6% N = 69	0% N = 0	26.2% N = 103	0% N = 0	17.6% N = 69
False	92.4% N = 363	82.4% N = 324	100% N = 393	73.2% N = 290	100% N = 393	82.4% N = 324
TOTAL	100% N = 393	100% N = 393	100% N = 393	100% N = 393	100% N = 393	100% N = 393

The table 5 shows that 7.6% of the respondents hide their identity online for fear of getting into trouble about what they post; while 92.4% do not. Also, 17.6% of the respondents hide their identity on the Internet for fear of Internet fraudsters and other online harmers; while 82.4% do not. Similarly, none of the respondents hide their identity on the Internet for fear that their contribution might not impress others all the time; while all do not do this. In the same vein, 7.6% hide their identity on the Internet to preserve their privacy; while 73.2% do not. Furthermore, none of the respondents hide their identity on the Internet because they are

reluctant to associate; all do not. Lastly, while 17.6% hide their identity on the Internet just for the fun of it; 82.4% do not.

Perception of Online Anonymity

The table 6 shows that 60.3% of the respondents believe that hiding of identity on the Internet enables people to freely give their views on issues; while 44% believe that hiding of identity on the Internet makes people irresponsible regarding what they post. Also, 62.6% think that hiding of identity on the Internet could spell danger to the society; while 56% believe that hiding of identity on the Internet could be good for the society. These data show that while a good number of the respondents have positive perception of the social consequences of online anonymity, a good number as well foresee some danger in that.

Table 6

Perceptions of Online Anonymity

	The fact that people can hide their identity on the Internet enables them to freely give their views on issues?	The fact that people can hide their identity on the Internet makes them irresponsible regarding what they post?	The fact that people can hide their identity on the Internet could spell danger to the society?	The fact that people can hide their identity on the Internet could be good for the society?
True	60.3% N = 237	44% N = 173	62.6% N = 246	56% N = 220
False	39.7% N = 156	56% N = 220	37.4% N = 147	44% N = 173
TOTAL	100% N = 393	100% N = 393	100% N = 393	100% N = 393

Effects of Online Anonymity

Table 7

Effects of Online Anonymity

	Anonymity boosts my motivation to use the Internet?	I feel safer expressing myself while anonymous online?	Being anonymous tempts me into making unethical/unlawful communication?
True	41.2% N = 162	27% N = 106	34.9% N = 256
False	58.8% N = 231	73% N = 287	65.1% N = 137
TOTAL	100% N = 393	100% N = 393	100% N = 393

The table shows that anonymity boosts the motivation of 41.2% of the respondents to use the Internet, while it does not do so to 58.8%. Also, 27% feel safer expressing themselves while anonymous online as against 73% that do not have the same experience. On the other hand, being anonymous tempts 34.9% into making unethical/unlawful communication online, while 65.1% are not so tempted.

Answering the Research Questions

Research Question 1**:** To what extent do young Internet users utilise online anonymity?

Firstly, it was established that all the respondents use the Internet. The most dominant uses they make of the Internet consisted of sourcing for news/information and for social networking. In the main, data gathered and analysed show that majority of the respondents have an online account (such as Facebook, Twitter, YouTube) which hides their true identity because the account bears neither their real name nor photograph. Similarly, majority admitted to have hidden their identity while making any post online by not using their real name or photograph. Based on the foregoing, it can be stated that because all of the young people use the Internet, it was no surprise that a significant proportion of the young Internet users are supposedly aware of what online anonymity entails and that they utilise online anonymity.

Research Question 2**:** How do these users perceive anonymity on the Internet?

The majority of the respondents are of the view that online anonymity promotes free speech, but do not think it makes people irresponsible in communicating online. However, while they are of the view that online anonymity could be dangerous for the society, they still believe that the society has something to benefit from it. Consequently, in answer to the second research question, while young Internet users perceive online anonymity as socially beneficial, they at the same time view it as potentially destructive.

Research Question 3**:** What are these users' reasons to be anonymous on the Internet?

In approaching this question, the data show that the number of respondents that utilise online anonymity due to privacy concerns emerged as the highest (26.2%), followed by the number that utilise it for fear of Internet fraud and other online harms, and the number that utilise it just for the fun of it—both of which stand at 17.6%. Therefore, the second research question is answered by admitting that the young Internet users utilise online anonymity mainly for the following purposes: first, to protect their privacy; second, to shield themselves against fraud and other online harms; and third, for the mere fun of it.

Research Question 4**:** What are the effects of online anonymity on these users?

Evidence from the data presented indicate that for majority of the respondents, anonymity does not boost their motivation to use the Internet, and neither does it make them feel safer expressing themselves, nor tempt them into making unethical/unlawful communication online. All these suggest that impact of anonymity on the Internet use habit of the respondents may not have been so strong. Consequently, it could be stated that being anonymous is not a motivating factor for using the Internet among the respondents, and that this has neither made them feel free to communicate nor lured majority of them towards communications that are ethically and legally undesirable. Still, the fact that those who agreed that being anonymous online tempts them into making unethical/unlawful communication, was a significant 35%, leaves room for further consideration of the possible negative effect of online anonymity on these users. This is further accentuated by the earlier significant 44% who affirmed that the fact that people can hide their identity on the Internet makes them irresponsible regarding what they post.

IMPLICATION AND CONCLUSION

Specifically, the findings of this study suggest that the youths in Anambra State in Nigeria are aware of what online privacy, Internet anonymity and disclosure are, as well as what are the attendant risks and benefits involved. Yet, it remains unclear why their attitude towards privacy, anonymity and self disclosure appears to be 'unserious' and dilemmatic. For instance, they know what these portend but they are unsure why they appropriate them. This suggests that these young people may not be fully ready to play by the rules of Internet privacy, Internet safety and cyber security. It may be safe to conclude that this is a cohort that wants to do their "own thing their own way", defying any conventions and schemas. Furthermore, this may be all too potentially destructive as more and more real life shared and lived experiences in Nigeria point to the dangers associated with youths not following the Internet safety rules: sexual harassments, identity thefts, hacking, cyberbullying, sex killings, ritual killings, frauds, etc.

Broadly put, the findings of this research generally suggest that anonymity has become an important component of Internet use culture among youths and it could have both positive and negative impacts on the users and the larger Nigerian society. However, these young users are not totally unaware of the possible social hazards of online anonymity. In other words, while they appreciate its potential social value, they are not totally oblivious of its potential dangers. This awareness, possibly, would contribute to cushioning the likely negative impact of anonymous use of the Internet in the Nigerian society. At least, being aware that hiding of identity on the Internet could compromise social norm and order, the conscientious ones among the young Internet users could be properly guided for healthier use.

Reflecting on the theories upon which this study was based, the findings of this study have opened some space for further reflection and analysis. For instance, the deindividuation theory has helped to conceptualise the tendency of individual users of the Internet to act "irresponsibly" while they remain anonymous on the Internet. According to the theory, an anonymous individual might feel him/herself "lost" in the crowd of multitude who exist in the cyberspace; his/her sense of individual responsibility could be lost. Thus, the user could be lured into doing acts he/she could not have done were his/her identity known. This scenario seemed emblematic of the university undergraduates that were studied in this research. Besides, the technological determinism perspective has itself proved that online anonymity–and other online behaviours–are creations of technology. In other words, the young Internet users in Anambra State, Nigeria, cannot but be anonymous–they are compelled to be anonymous according to the determination of the technology known as the Internet. Notably, it had earlier been surmised that past research literature have generally shown that Internet access is widespread among this category of Nigeria's population (Ojokoh & Asaolu, 2005; Mishra, 2009; Bankole & Babalola, 2012; Fasae & Aladeniyi, 2012; Ekweli, 2014; Uzuegbunam, 2015).

This study has attempted to address the tensions surrounding anonymity among selected young Internet users in Nigeria in contemporary social media platforms. It ultimately contributes to a tradition of research on the dualism of privacy, privilege, and social interaction (Walther, 2011) that online communication has incurred over the times.

RECOMMENDATIONS

Based on the findings and conclusions of this study, the following recommendations were deemed germane by the authors:

1. More studies pertaining to the subject could be conducted, especially to utilise other research methods such as focus group and participant observation, to unravel the earlier noted point of why young people's attitude towards privacy, anonymity and self disclosure appears to be unserious and dilemmatic. Furthermore, it may be important to also have a comparative analysis of online anonymity and privacy issues between and among other places in Nigeria.
2. Internet literacy education should be incorporated in the Nigerian school curriculum beginning from the primary school level, as this is currently largely non-existent. This is with the view to start educating people from their early years on not just the skill but on ethics and other principles of healthy Internet use. This is particularly relevant today when new media access is becoming more common even amongst children.

3. Civil society groups, political educators, health educators and other development communicators in Nigeria should be encouraged to optimise use of the Internet in engaging the audience, particularly the young ones. If the youths are so usefully engaged online, possibly, it may be that they could be occupied with more socially useful communication while on the Internet as against playing mischief and engaging in other socially destructive habits.

Acknowledgement

The authors wish to acknowledge the support of the International Association for Media and Communication Research (IAMCR) towards the cost of the conference that propelled this research. The lead author received a travel grant award from the association to present earlier version of this paper at the 2016 edition of IAMCR conference held at University of Leicester, United Kingdom.

REFERENCES

ADENIRAN, A. I. (2008). The Internet and emergence of *Yahooboys* sub-culture in Nigeria. *International Journal of Cyber Criminology*, *2* (2): 368–381

ADEPOJU, J. T. (2003). *Mass communication research*. Ibadan: Sceptre Prints Limited.

AMAEFULE, E. (2012). Nigeria joins top 20 Internet nations. Retrieved from http://thepunchonline.com/news/Nigeria_joins/

ANASI, S. (2006). Internet use pattern of undergraduate students at the University of Lagos, Nigeria. *University of Dar es Salaam Library Journal*, *8* (1), 1–15.

AWOLEYE, O. M., SIYANBOLA, W. O., OLADIPO, O. F. (2008). Adoption assessment of internet usage amongst undergraduates In Nigeria universities – A Case study approach. *Journal of Technology Management and Innovation, 3*(1): 84–89

ARMSTRONG, H. L., FORDE, P. J. (2003). Internet anonymity practices in computer crime. *Information Management & Computer Security*, 11 (5): 209–215. Retrieved from http://dx.doi.org/10.1108/09685220310500117

BANKOLE, O. M., BABALOLA, S. O. (2012). Internet use among undergraduate students of

Olabisi Onabanjo University, Ago Iwoye, Nigeria. *Library Philosophy and Practice (e-journal).* Paper 812.

BARAN, J. S., DAVIS, D. K. (2001). *Mass communication theory: Foundations, ferment and future* (Third Edition). Belmont, CA: Thomson Wadsworth.

CHRISTOPHERSON, K. M. (2007). The positive and negative implications of anonymity in Internet social interactions: "On the internet, nobody knows you're a dog". *Computers in Human Behavior, 23* (6): 3038–3056. Retrieved from http://www.sciencedirect.com/science/article/pii/S0747563206001221

DAVENPORT, D. (2012). Anonymity on the Internet: Why the price may be too high. Communications of the ACM, *45* (4): 33–35

DREYFUS, H. L. (1998). Education on the Internet: Anonymity vs. Commitment. *The Internet and Higher Education, 1* (2): 113–123. Retrieved from http://www.sciencedirect.com/science/article/pii/S1096749499801743

EKWELI, O. O. (2014). Patterns of Internet use among university undergraduates in Anambra State [Master's degree thesis]. Department of Mass Communication, Nnamdi Azikiwe University, Awka, Nigeria.

FASAE, J. K., ALADENIYI, F. R. (2012). Internet use by students of faculty of science in two Nigerian universities. *Library Philosophy and Practice 2012*. Retrieved from http://unllib.unl.edu/LPP/
FROOMKIN, M. (1996). The Internet as a source of regulatory arbitrage. Retrieved from http://osaka.law.miami.edu/~froomkin/articles/arbitr
LEONARD, B. O. (2008). *Towards a technological discourse.* Beverly Hills: Sage Publications
LONGE, O. B., CHIEMEKE, S. C., ONIFADE, O. F. W., BALOGUN, F. M., LONGE, F. A. & OTTI, V. U. (2007). Exposure of children and teenagers to internet pornography in South Western Nigeria: Concerns, trends & implications. *Journal of Information Technology Impact*, *7* (3): 195–212
LONGE, O. B., LONGE, F. A. (2005). The Nigerian web content: Combating pornography using content filters. *Journal of Information Technology Impact, 5* (2): 59–64
INTERNET WORLD STATS (2016). Usage and population statistics. Retrieved from http://www.internetworldstats.com/africa.htm
JAGBORO, K. O. (2003). A study of Internet usage in Nigerian universities: A case study of Obafemi Awolowo University, Ile-Ife, Nigeria. First Monday *First Monday*, *8 (*2): 1–31
KAYODE-EDEBOR, K (2011). Internet usage by Nigerian secondary school students: A case study of selected students in Ibadan metropolis. *Information Technologist 8* (2): 99–110. Retrieved from http://www.ajol.info/index.php/ict/article/view/77361
MAYER, J. R. (2009). "Any person... a pamphleteer": Internet Anonymity in the Age of Web 2.0 [Bachelor's degree thesis], Faculty of the Woodrow Wilson School of Public and International Affairs.
MELVIN, J. Y. (1999). Uses and gratifications approach. Retrieved from http://www.utwente.nl/cw/theorieenoverzicht/Theory%20clusters/Mass%20Media/Uses_and_Gratifications_Approach.doc/
MISHRA, M.K. (2009). Use and importance of the internet at the University of Maiduguri,
Nigeria. *First Monday*, *14*(3):11 – 33
MOORE, S. (2008). The challenge of internet anonymity: Protecting John Doe on the Internet. *Computer & Info. L.*26 (469). Retrieved from http://heinonline.org/HOL/LandingPage?handle=hein.journals/jmjcila26&div=23&id=&page=
NWAGWU, W. E. (2007). The Internet as a source of reproductive health information among adolescent girls in an urban city in Nigeria. *BMC Public Health*, 7:354. Retrieved from http://www.biomedcentral.com/1471-2458/7/354
OJOBOR, I. J. (2002). Mass communication theories. In C. S. Okunna (ed.). *Teaching mass communication: A multi dimensional approach* (p.1 – 26). Enugu: New Generation Books.
OLOGBO-ORI, T. (2005). *Internet as a medium of communication.* Lagos: Awo Limited.
OLOWA, O. W. (2012). An Assessment of Internet uses, practices, and barriers for
professional development by agricultural science teachers in Lagos State. *Education Research International*. Retrieved from http://www.hindawi.com/journals/edri/2012/503264/
OMOTAYO, B.O. (2006). A survey of Internet access and usage among undergraduates in an
African University. *The International Information and Library Review* 38: 215-224.
PALME, J., BERGLUND, M. (2007). Anonymity on the Internet. Retrieved from http://people.dsv.su.se/~jpalme/society/anonymity.html
SOBEL, D. L. (2000). The Process that "John Doe" is Due: Addressing the Legal Challenge to Internet Anonymity. *Virginia Journal of Law & Technology5* (1). Retrieved from http://www.vjolt.net
UZUEGBUNAM, C. E. (2015). Young people's engagement of social media for social transformation: A study of Nigerian University students. *Online Journal of Communication and Media Technologies*, Special Issue – September 2015, 171–194.
WALTHER, J. B. (2011). Introduction to Privacy Online. In S. Trepte and L. Reinecke (eds.), *Privacy Online, Perspectives on Privacy and Self disclosure in the social web*. Springer-Verlag Berlin Heidelberg. DOI 10.1007/978-3-642-21521-6_1.

NICHOLAS A. JOHN, *The Age of Sharing*, Polity Press, 2017, 200 pp.

The book has appeared as a project for a postdoctoral research integrated in the domain of communication studies for the social interaction in digital era, but, not only. IN the acknowledgements, the author has confessed that the starting point of the research has been in the Department of Communication and Journalism at the Hebrew University in 2010, with a topic for a post-doctoral research involving the key concepts – globalization and multichannel television. The challenge has been much bigger when the issue has been directed to sharing**.** But the subject has become a disease, being contagious, so that he has to share the information about the definition, meaning, interpretation and evaluation of sharing as a dynamic concept with colleagues, friends, experts and, even family. The result a research materialized in a book, object and subject of this review.

Sharing has been defined in a three dimensional perspective: (i) as a constitutive activity of social media; (ii) as a model of economic behaviour according to our human condition in everyday life: producer and consumer and (iii) sharing as a category of speech. These three trends have suggested a functional and constructivist framework denominated as 'the spheres of sharing' with their methodology. In this regard, the book has tried to reveal to the reader in an empirical mood the implications of technologies as mediators/ intermediators of our lives, but, also, the condition of a human being in a network society, where we are producers and consumers of goods-material or immaterial-see information as good. Creating content in market driven daily life and the emotional dimension of our life in the social interactions involved in our life in either formal or non-formal contexts are other two approaches offered by the author. Thus, sharing has engaged a set of values proving that the concept has become the embodiment of an entity with form and content, with form and meaning as any other social institutions.

The conceptual mapping perspective has been developed in the structure of the book marked by an argument with an overview of the scholars interested by sharing as a rationale for research. The author has focused on current studies about digital culture [Meikle, 2016][1], digital anthropology, the consequences of sharing upon consumer behaviour [Belk, 2014][2], defined in the quotation as a 'a type of

[1] Apud John, 2017: 13-Meikle, G. (2016). *Social Media: Communication, Sharing and Visibility*, New York, Routledge.

[2] Apud John, 2017:13, Belk, R. (2014). Sharing versus pseudo-sharing in *Web 2.0. The Anthropologist 18/1:* 7–23.

Rom. Jour. of Sociological Studies, New Series, No. 1, p. 107–113, Bucharest, 2017

(cc) BY-ND
Creative Commons License
Attribution–NoDerives CC-BY-ND 4.0

third distribution'. The works of the scholars used as resources for the current interpretation has been evaluated in a critical view. Marking the practices of sharing in media, communication and society, Nicholas A. John has accepted the stance of other scholar Kennedy[3] in 2013 and 2016 that our use of term seemed to promote pointing practices that 'are not really' sharing. The originality of the book consist in explaining why it is necessary to research the practice in the spheres suggested, interpreting the sharing as a type of communication that implies interpersonal relations, roles assumed by the participants in social interaction, even the symbolic one, and evaluating the contract of communication in sharing throughout economic, political and cultural dimensions as a social institution. The style the book is written has invited the reader to join the community by using 'our society is..', 'we understand that..' offering the opportunity for participating and sharing the points of view or not.

The author, Nicholas A. John, has proved his keen interest in knowledge and his background in education and career by the well-organized text, starting with the definition of sharing from multiple sources; Oxford English Dictionary, but he has focused on the polysemantic keyword sharing**,** with its economic, political, cultural, sociologic, linguistic, communicative approaches. Following coherent the text, the reader can find the interpretation of sharing by the application of the pattern for research in certain perspectives; the technological one throughout new media and social media – chapter 'Sharing and Internet', the economic behaviour in our daily lives as producers and consumers – chapter 'Sharing Economics', and, the last one the personal emotions with the consequences in our everyday life, namely advantages and disadvantages of sharing as social practice in interaction. Important for recommending the book, it is the critical analysis of sharing as constitutive activity of the new media and social media, the biases of the model for production and consumption and as a type of talk, discursive practice in everyday conversation, debate or other form of social interaction.

The book, *The Age of Sharing*, has given the opportunity for the author, not only to research the issue, but to give much more information in communicating science, the concept of sharing in different contexts. One, the author has emphasized, is the Dave Eggers's novel 'The Circle' published in 2013[4]. The narrative has main reference a Silicon Valley company specialized in IT presented by the new employee perspective, Mae. Company has a slogan – intertextuality can explain more – 'Secrets are lies. Sharing is caring Privacy is theft'. The Mae's experiences of sharing or not her personal life have become topic of chat with her boss. It is or not sharing an intrusive tool in our personal life? A question the reader puts at the end. But the conclusion has been obvious, the sharing is a social practice

---

[3] Apud John, 2017:15. Kennedy, J. (2014) Sharing in networked culture, imagination, labour and desire (Phd dissertation). Melbourne. Victoria: Swinburne University, and Kennedy, J. (2016). Conceptual boundaries of sharing. *Information Communication & Society19/4:* 461–74.

[4] Apud John, 2017: 151. Eggers, D. (2013). *The Circle-a novel.* Penguin Books.

which might close social gaps, but, according the author's own words, the sharing 'seems to be restorative from excesses of capitalist society". The set of values that sharing is offering can be positive or negative, but quoting Raymond Williams, it is a social practice materialized in a keyword that 'some important social and historical processes occur *within* language'. [Williams, 1976: 22][5] This final remark has given the reviewer a personal thought we are sharing, but we are not caring, what we can do with the language in use.

The title of the book has created in our minds the historical perspective of the usage of sharing, Nicholas A. John has gone back in time to the Oxford Group, the first community around 1930, which has organized a type of intimate talk to community parties, where people have been sharing. The Chapter 'Sharing our Feelings' has analyzed and evaluated discussions from the group. The multiplication of the modality for the Anonymous Alcoholics has created a therapeutically approach. While in American counterculture has been used, in the mid of 20th century – 1960–1970, as a form of self-expression and consumerism.

At the end of the book, the author has expressed its research evaluation: 'Pragmatically speaking, sharing represents an alternative to capitalism, and at the same time it is the mode of our participation in its cutting edge. Sharing is a type of communication I use when I want to discuss personal matters of import with my significant other, but when we I do that with the assistance of communication technologies, my communication is commodified. This is the paradox of sharing … sharing combines digital culture with therapy culture with an attractive model of economics' [John, 2017: 154]. Although it is a personal evaluation has been based on an accurate research from a Critical Discourse Analysis approach, but with a subjective view focused on scientific bibliography and other resources which have given the reader the opportunity to read more and to find out much more information in non-scientific resources as novels, cultural events.

Nicholas A. John has suggested to read the book as an exercise for a lively mathematics: 'The outcome of this exercise is thus greater than to sum up its parts: sharing emerges as a complex and contradictory set of practices and meanings through we can read and make sense of large swathes of contemporary society: it is a normative yardstick by which we evaluate the way we live'. If you read the book *The Age of Sharing*, you can find the childhood and the youth of the concept, and to evaluate de tradition and the innovation of the meanings at the maturity the concept is living now.

As any book, which has been read in a bookshop and it has been bought by the interest for the domain, the most important recommendation offered by one scholar – in the area of IT: Nancy Baym, principal researcher at Microsoft Research – 'the word sharing has become so ubiquitous that rarely stop to inquire into its meanings, let alone the ideological work it does in diverse contexts of its

[5] Apud John, 2017:155, Williams, R. (1976). *Keywords. A vocabulary of culture and society.* Oxford: Oxford University Press

use. John's engaging historical analysis of sharing across three domains is essential reading, offering deep insight into the implicit values that shape our interactions and economies'.

ANA-MARIA TEODORESCU

RITA CHARON, *Narrative Medicine – Honoring the stories of illness*, Oxford University Press, 2006, 266 pp.

As oddly as it could have sounded before becoming a respected discipline in clinical studies of medicine, narrative medicine has gained weight after icebreakers like Rita Charon, MD. Narrative medicine is defined as medicine practiced with consideration to the stories of illness, expressed along the doctor-patient relationship. The stories of illness, as told by the patients and received by their doctors are filled with metaphors, life stories, symbols and narrative concepts. Rita Charon has been the pioneer in narrative medicine writings, explaining at the beginning of the book how she became involved in what later on it became a medical discipline, focused on delivering better medical services, with a real concern to patient suffering, paying attention to what they say, feel and develop as personal story of illness and, eventually, death. The book covers the issues of terminal illnesses and dealing with terminally ill patients, who have very particular stories as seen by them, by their families and, lastly, their caretakers and physicians.

The book is structured in four parts – Part I explaining the concept of narrative medicine "What Is Narrative Medicine", Part II is focused on the narrative of illness – "Narrative of Illness", Part III touches the more practical aspects on how to develop narrative competence – "Developing Narrative Competence" and Part IV, about the benefits of narrative approach with the patients, "Dividends of Narrative Medicine".

As for a relatively new hybrid area of study, the first two chapters of the book focus on defining what narrative medicine is, as a necessary explanatory and quite didactic approach. Paying attention to narrative elements in personal stories could lead to better care, more efficient and more humane approach to illness and death. It is a win-win situation for both doctors and patients, but the reader should not get mesmerized with only narrative. Medicine practiced with narrative knowledge is still medicine, as we know it, only more patient-focused. Basically, it could offer a solution of how to fit all medical information one doctor receives from its patients in a very short-timed visit, while he describes how he feels, how his suffering is consuming his everyday life and what his story truly is.

While explaining the benefits of narrative medicine as a better approach to patients and their stories, Charon touches the reason the understanding gap between health practitioners, patients and sometimes their families occurs. One description

of the reason this gap occurs is in the second chapter “Bridging Health Care’s Divides” where Charon mentions that no matter how knowledgeable the health practitioners are in their services, about the diseases they cure, they sometimes may be ignorant of the abyss their patients stand due to the fact they experience frightening signs of illness, weakness, changes and terror (Charon, 2006, 19). One other differentiator in patient-doctor relationship is the imagination, or ”imaginary scenario” (Charon, 2006, 20) which immensely differ one from another – the doctor cannot and would not walk in his patient’s shoes, while the patient is already imagining life beyond the doctor-patient encounter while fighting with fear and effects of an illness.

One special mention should go to the concept of “dignity” and “dignifying” the lives of the sick people the doctor interacts with in his practice. Doctors are all together united in the effort to treat patients, which gives them the capacity to dignify the suffering and the stories of illness (Charon, 2006, 226). The patient’s self has to be the same or at least as inserted and associated with healthy people, to feel that he hasn’t changed after falling ill and his dignity as a human being is intact.

While considering the doctor-patient interaction, although trained and detached from emotions while treating a patient, the doctors themselves suffer “conflicting delusions” (Charon, 2006, 23), especially about death. While the majority of Charon book’s readers are not necessarily doctors, the insight she gives on how the doctors feel are valuable and explanatory. It appears that doctors are torn apart in two conflicting delusions – the medical training they pursue have them believe at some level that they are immortal, but confronted with their patient’s mortality, doctors become aware of the terminal effects of some illnesses. Doctors, being exposed to death, acquire one irrational belief that they are immortal themselves. On the other hand, patients have their own rapport with death –either feeling death is a close enemy or a distant abstraction, based on their own experience with it.

To be able to listen to a story, one should know there is a story unfolding before him. Charon pinpoints that the way of changing the patient-doctor dynamics in regular interviews is to pay attention to the story the patient is trying to tell, even if he’s not using words. “Listening to the stories is what we in health care must learn to do. To listen for stories, we have to know, first of all, that there are stories being told” (Charon, 2006, 67). Except for the psychiatrists and mental health professionals, there are very few medical doctors who listen and interpret the metaphors, the mundane elements, personal issues, intimate details or apparently non-related things that occur in patient’s discourse. They, based on Charon’s evaluation, are not interested nor trained to listen “with the third ear” (Charon, 2006, 67) as, for instance, psychoanalysts.

The benefits of listening with the third ear could be found in the concept of patient-centered-care, honouring the stories of illness as means of a better, sympathetic medical care with better results, comforting the patients and his

family. Charon defines four types of divides which set distance between patients and their caretakers: *the relation to mortality* (the way doctors and patients relate so differently to death, doctors accepting it as a material fact of life, looking at it from almost technical point of view, while patients being unprepared for death, depending on their own and personal experience about passing); *the context of illness* (doctors rather see the event of sickness as a separate event, while patients frame the illness within their entire life); *beliefs about disease causality* (the ideas about the cause and symptoms of a disease are sometimes deeply conflicting, as seen by doctors and patients); *the emotions of shame, blame and fear* (these are not the only emotions populating the illness's landscape, but one of the most powerful – those emotions of shame, blame and fear, if not explicitly discussed could irrevocably distance the patient from his doctor) (Charon, 2006, 21).

Trying to explain and close the gap between doctors and patients, in order to get better, more humane and efficient health care, the book shows that actually the distance is not that significant if paying attention to the narratives. The benefits of acknowledging there is a story to be told by the doctors themselves became evident when medical practitioners began writing about their own patients and experiences with illness and death. Doctors who write about their experiences with patients are becoming more numerous after Charon's book was published in 2006, but even before with Oliver Sacks's non-fiction "Awakenings" published originally in 1973, depicting the life histories of those who had been victims of the 1920s encephalitis lethargica epidemic. Nowadays, we have the works of Danielle Ofri, Louise Aronson, Barron H. Lerner, Sandeep Jauhar, Perri Klass, Jerome Groopman, Lisa Sanders or Atul Gawande, focusing on the doctor-patient relationship. Linking the dots between what doctors and patients feel makes the medical approach more personal, aware of individual stories, more connected, and therefore more efficient.

As Charon explains, all the medical doctors writing about their patients became aware of how urgent is to reflect on their own lives and perceptions to illness and death, not being immune to emotions and perceptions.

As for a better and more efficient health service, Charon recalls the story of a gastroenterologist who's patient was in for bulimia (Charon, 2006, 79), but after managing to listen to her story he found out, just in attentive conversation, that the patient had in addition to what seemed to be an eating disorder, frightening nightmares. The gastroenterologist just went above his specialty and evaluated those nightmares as signs of sexual abuse, which the patient was trying to cope by eating; therefore he referred her to a psychotherapist in order to help the patient targeting the root of her sufferance. Eventually, the patient was healed, resumed college studies and improved her life situation.

One special section is dedicated to the bioethics of narrative medicine – as the doctors and the medical personnel has access to patients story, particularities, and sometimes information which they are prevented by the medical ethics to share

or to use for a different purpose but trying to heal the patients and "accompany them on their journeys" (Charon, 2006, 203).

Medical practitioners have to have skills, concludes Charon. Apart from interviewing the patients from clinical perspective, doctors must listen to several voices – voices of illnesses, voices of body, voices of patient's emotions. Sometimes these seem not related, as in the rape victim's case that went to see a gastroenterologist for her eating disorder. In the same time "narrative, by its nature, is disruptive. Unlike lists or formulas, narrative is not clean, predictable, or obeisant." (Charon, 2006, 217). But the advantages of narratives in medicine are innumerable – it builds bridges among health care professionals, patients and communities, to decrease what, inevitably, are present in healthcare (Charon, 2006, 228).

"What is required is the skill of stereophonic listening, the ability to hear the body and the person who inhabits it. What is required is the capacity to recognize the many voices of sickness – in their contradiction, their secrecy, and their exposure of the self" (Charon, 2006, 97).

Time has never been a friend of overworked health practitioners. Developing narrative skills in medicine could improve the doctor-patient relationship and this is the "honouring the stories of illness" mean in Rita Charon's book.

REFERENCES

SACKS, O. (1983). Awakenings, 1973, rev. ed. *New York: Dutton*, 3.

OFRI, D. (2013). What doctors feel: how emotions affect the practice of medicine, Beacon Press.

ARONSON, L. (2013). A History of the Present Illness. Bloomsbury Publishing USA.

LERNER, B. H. (2014). The good doctor: a father, a son, and the evolution of medical ethics, Beacon Press.

JAUHAR S. (2007). Intern: A doctor's initiation, Macmillan.

KLASS, P. (1988). A not entirely benign procedure: Four years as a medical student. Signet.

GROOPMAN, J. E., & Prichard, M. (2007). How doctors think (pp. 177–202). Boston: Houghton Mifflin.

SANDERS, L. (2010). Every patient tells a story: medical mysteries and the art of diagnosis. Harmony Books.

GAWANDE, A. (2014). Being mortal: medicine and what matters in the end. Macmillan.

IOANA SILISTRARU

THE AUTHORS

VALENTINA MARINESCU is Professor Habilitated at the Department of Sociology, Faculty of Sociology and Social Work, University of Bucharest, Romania. She teaches methods of research in communication sciences, introduction in communication and sociology of mass media both at the BA and MA level. Her main research interests are: communication and media studies. Since 2013 she is Romanian representative in Management Committee of the COST project ISCH 1206 Femicide across Europe. She was Regional Evaluator (Romania and Macedonia) for Roma Education Fund program "Improving the targeting of government support to Roma students in tertiary education" and Country Evaluator of WINNER II Romania for UNIFEM and International Bank for Reconstruction and Development. Her recent publications were: Marinescu, V., Mitu, B. (eds.) Health and the Media: Essays on the Effects of Mass Communication. McFarland, 2016; Marinescu, V., Mitu, B. (eds.). The Power of the Media in Health Communication. Routledge, 2016; Marinescu, V., Branea, S. (eds.) Exploring Political and Gender Relations-New Digital and Cultural Environments. Cambridge Scholars Publishing.

RAMONA MARINACHE graduated sociology, bachelor and master degree at the Faculty of Sociology and Social Work, University of Bucharest. In 2013 she obtains her PhD degree from the Social School of Sociology, University of Bucharest with a thesis on sociology of sleep. During her PHD studentship she had a visiting fellowship at the University of Manchester. In 2014 she obtained a one year postdoctoral grant at the University of Bucharest to continue her research on the social practices of sleep. From 2010 to 2016 she was a teaching assistant for the seminars of 'Sociology of the Body', 'Methods of Sociological Research', 'Social Psychology' and 'Sociology'. In 2017 she lectured the course 'Methods of Social Research' at the Department of Cultural Studies, Faculty of Letters, University of Bucharest. From 2015 she had collaborations with the Faculty of Social and Human Sciences, 'Lucian Blaga' University, Sibiu; Faculty of Management, The Bucharest University of Economic Studies and Faculty of Letters, University of Bucharest. Along sleep practices her research interests encompass dreams and dreaming though the lenses of three main paradigms – sociology of the body, sociology of automobility and anthropology of health and illness.

Rom. Jour. of Sociological Studies, New Series, No. 1, p. 115–118, Bucharest, 2017

(cc) BY-ND
Creative Commons License
Attribution–NoDerives CC-BY-ND 4.0

CHIKEZIE EMMANUEL UZUEGBUNAM is a lecturer with Department of Mass Communication, Nnamdi Azikiwe University, Nigeria. Currently, he is a doctoral scholar at the Centre for Film and Media Studies, University of Cape Town, South Africa, where his research focuses on teenage children's engagement and experiences with new media technologies in Nigeria. His research output have been published by notable publishers such as Routledge, Taylor & Francis, Intellect, Cambridge Scholars Publishing, and he has equally participated in notable international conferences in Europe, Asia, Middle East and Africa. In 2015, he was a Visiting Scholar at Xiamen University, China. He received training on the course "African Media in a Global Age" by London School of Economics and Political Science. Passionate about youth development, mentoring leadership and youth advocacy, he has been involved with research consultancies around the young population. For two years, he worked with the Ministry of Education to consolidate research on Out-of-School children and the Girl-child education. He is a member of the preeminent International Association for Media and Communication Research (IAMCR) and his research interests are focused around new media, young people's research, popular culture, political communication, and ethics of communication – areas in which he has published. He serves as Editorial Reviewer for IMC Review, Roosevelt University, and Chicago.

HENRY CHIGOZIE DURU is an author and journalist, and currently works as the editor of *National Liberator* newspaper in Nigeria as well as engaged in media consultancy. He earned his Bachelor of Science and Masters of Science degrees in Mass Communication as well as a Postgraduate Diploma in Education (PGDE). He is currently a PhD candidate in Mass Communication at Nnamdi Azikiwe University in Nigeria with his research focusing on language, ideology and power in newspaper representation of ethnic affiliations in Nigeria. He has presented a number of conference papers and has a number of academic publications to his credit. His major areas of scholarly interest are mass media and conflict, media law and ethics, and sociology of mass communication.

RAHUL BHAUMIK holds a master's degree in history from the Department of History, Jadavpur University, Kolkata and completed his doctoral research focusing on the history of colonial snakebite medicine in British India from the same department in 2016. He was formerly a Junior Research Fellow of the Indian Council of Historical Research, New Delhi. At present, he teaches undergraduate history in a college under the University of Burdwan and is currently engaged in finalising a monograph based on his doctoral thesis. One of his articles was published in the *History Studies: International Journal of History*; another is forthcoming from the *Indian Journal of History of Science*. His main research interests include history of colonial science and medicine in South Asia.

CARMEN VOINEA is a PhD student at the Faculty of Sociology and Social Work, University of Bucharest, since 2015. Her research is exploring the plastic surgery phenomenon in Romania, concentrating on the negotiation of the surgical change between the patient and the aesthetic surgeon as reflexive actors in the context of a consumer society. She has a bachelor's degree (2006) in Political Sciences from University of Bucharest and a master's degree from Faculty of Sociology and Social Work, University of Bucharest (2010).

ALEXANDRA CIOCĂNEL is a PhD student in Sociology at the University of Bucharest, Faculty of Sociology and Social Work. She holds a bachelor's degree in Architecture and one in Sociology, and in 2015 she graduated the courses of the Master Programme *Anthropology and Regional and Community Development* at the Faculty of Sociology and Social Work, University of Bucharest. Her general research interests are in Science and Technology Studies, Medical Anthropology and Sociology, Sociology of Work and Professions, Practice Theories and Discourse Studies. In her dissertation project, she studies medical pluralism through an ethnographic study of homeopathy. She examines various material and discursive practices that patient and practitioners engage in their efforts to maintain and restore health and how these construct an alternative/complementary medical reality.